

**SUMMARY PLAN DESCRIPTION
FOR
*BEDFORD CENTRAL SCHOOL DISTRICT
GROUP HEALTH BENEFITS PLAN***

**(A self-funded health benefits plan for employees
of Bedford Central School District)**

IMPORTANT REMINDERS

ENROLLMENT

Failure to report enrollment changes could result in overpayment or denial of benefits. You will be required to reimburse the full amount of any benefit overpayment. Refer to **Section II - Eligibility and Enrollment** for details.

You must keep your *enrollment* information updated. It is important that you notify the District Benefits Office immediately for the following:

- Change in marital status
- Birth of a child or addition of a child
- Address change and phone number change
- Student status of child age 19 or older
- Enrolled disabled child approaching age 19
- Marriage of your Dependent child
- Any Family Member death
- Other group health plan information, including effective dates of Coverage and name and address of the other group health plan(s)
- If you or your Dependent become eligible for Medicare due to disability, age or End Stage Renal Disease

COBRA CONTINUATION OF COVERAGE

Written notice of most qualifying events must be sent to the Bedford School District Benefits Office within **60 days** following the event. If written notice is not given within 60 days, continuation of Coverage under COBRA will not be available. Refer to **Section II - Eligibility and Enrollment** under *Continuing Coverage under COBRA* for details.

BENEFIT MANAGEMENT PROGRAM

Inpatient admissions to Hospitals or other facilities, home health care, Durable Medical Equipment and certain medical procedures may require a mandatory phone call before services are rendered. Failure to follow phone call requirements could result in reduced Plan benefits. Refer to **Section III - Benefit Management Program** for details.

Please Note

*All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions. You must comply with requests for additional medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. **Treatment decisions are independent from payment decisions.** The patient's Physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in, or excluded from, Coverage under the Plan.*

TABLE OF CONTENTS

INTRODUCTION..... 1
PLAN IDENTIFICATION..... 1
Medical Benefits Claims Administrator 2
Prescription Drugs Claims Administrator..... 2
Benefit Management Program Administrator 2

SECTION I - SUMMARY OF BENEFITS 3
SUMMARY..... 3
Network and Out of Network Expenses..... 3
Full Benefits..... 3
Allowable Fees 3
 Out of Network Providers. 3
 Network Participating Providers..... 3
PREVENTIVE CARE EXPENSE BENEFITS..... 4
Well Child Care 4
Adult Routine or Well Care 4
Out-of-Network 5
HOSPITAL EXPENSE BENEFITS (HEB) 6
Hospitals and other Facilities, Agencies 6
General Hospital 6
 Hospital Inpatient Care..... 6
 Hospital Outpatient Care..... 6
Certified Birth Center 7
Skilled Nursing Facility..... 7
 Inpatient 7
Ambulatory Surgical Facility 7
Kidney Dialysis..... 7
Home Health Agency..... 7
Hospice Agency 7
Alcohol Abuse Facility or Agency..... 8
 Inpatient Alcohol Rehabilitation..... 8
 Outpatient Alcohol Rehabilitation 8
Ambulance..... 8
MAJOR MEDICAL EXPENSE BENEFITS..... 8
Deductibles, Copayments and Benefit Maximums..... 8
Major Medical Covered Expenses and Benefit Limits..... 10
General Hospital 10
Psychiatric Inpatient 10
Psychiatric Outpatient 10
Substance Abuse Facility..... 10
 Substance Abuse Inpatient..... 11
 Substance Abuse Outpatient..... 11
Ambulatory Care Facility 11
Other Medical/ Surgical Office Services 11
 Office Visits..... 11
Specialist Consultations 11
 Outpatient..... 11
 Inpatient 11

Mandatory Second Opinion Consultation	11
Voluntary Second Opinion	11
Second Surgical Opinion	12
Surgery	12
Inpatient Physician Visits	12
General Anesthesia	12
Chiropractic Care	12
Chemotherapy	12
Diagnostic Tests	12
Durable Medical Equipment	12
Ambulance	12
Professional Nursing	12
Wig/Hairpiece	13
All Other Covered Services	13
PRESCRIPTION DRUG EXPENSE BENEFITS	13
Secondary Coverage	13
Pharmacy	14
Drug Copayments	14
Mail Order Pharmacy	14
POTENTIAL CAUSES FOR BENEFIT REDUCTION	14
Please Note	15
SECTION II - ELIGIBILITY AND ENROLLMENT	16
ELIGIBILITY FOR PLAN ENROLLMENT	16
Active Employees/Retirees	16
Dependents	16
Legal Spouse	16
Your Unmarried Children	16
Child Definition	17
Qualified Medical Child Support Orders	17
Survivor Dependent Eligibility	18
Leave of Absence	18
ENROLLMENT	19
Individual Coverage	19
Family Coverage	19
Enrollment Changes	19
EFFECTIVE DATES OF BENEFITS	19
Employee/Retiree General Rules	19
Dependent	20
Special Enrollment Effective Dates	20
Adding New Dependents	20
Cancellation of Another Health Plan	20
PLAN PARTICIPATION CONTRIBUTIONS	21
END OF COVERAGE	21
VESTED EMPLOYEE CONTINUATION OF COVERAGE	22
General Eligibility Rules for Vested Rights	22
Requesting Continuation of Coverage While in a Vested Status	22

CONTINUING COVERAGE UNDER USERRA.....	23
CONTINUING COVERAGE UNDER COBRA.....	23
Qualifying Events and Notification.....	23
Continuation Period.....	24
Acquiring Dependent Children.....	24
COBRA Participation Payment.....	25
COBRA Election Forms.....	25
End of COBRA Coverage Continuation.....	25
COBRA Coverage and Preexisting Conditions.....	26
PLAN CANCELLATION.....	26
SECTION III - BENEFIT MANAGEMENT PROGRAM.....	27
Preadmission Review.....	27
Mandatory Enrollee Telephone Requirement.....	28
Noncompliance Benefit Reduction.....	28
CONCURRENT REVIEW.....	28
MEDICAL CASE MANAGEMENT/DISCHARGE PLANNING.....	28
MEDICAL PROCEDURE REVIEW.....	29
Mandatory Enrollee Telephone Requirement.....	29
Mandatory Second Opinion Consultation.....	29
SOC Noncompliance Benefit Reduction.....	29
VOLUNTARY SECOND OPINION CONSULTATION.....	29
DURABLE MEDICAL EQUIPMENT REVIEW.....	30
SECTION IV - COVERED SERVICES.....	31
Federal Mastectomy Provision Notice.....	31
PARTICIPATING PROVIDER NETWORK PROGRAM (NETWORK).....	31
PREVENTIVE CARE EXPENSE BENEFITS.....	32
Well Child Care.....	32
Newborn Nursery Care.....	33
Well Child Care/Immunizations.....	33
Adult Routine or Well Care.....	33
Cervical Cytology/Pap Test and Exam (Network Only).....	33
Mammography Screening.....	34
Prostate Cancer Screening Program.....	34
HOSPITAL EXPENSE BENEFITS.....	34
General Hospital.....	34
Inpatient Services.....	34
Room and Board.....	34
Hospital Miscellaneous.....	34
Medical/Surgical Benefit Limit.....	34
Psychiatric Care Limit.....	35
Pregnancy or Maternity.....	35
Newborn Nursery Care.....	35
Outpatient Services.....	35
Emergency Care.....	35
Surgery.....	35
Radiation Therapy.....	35
Diagnostic Testing.....	36
Preadmission Testing.....	36

Kidney Dialysis.....	36
Physical Therapy.....	36
Other Hospital Outpatient.....	36
Birth Center Facility.....	37
Skilled Nursing Facility/Rehabilitation Facility (SNF) Inpatient Care.....	37
Coverage Criteria.....	37
Covered SNF Services.....	37
Home Health Care Agency.....	37
Hospice Agency.....	38
Alcohol Abuse Facility.....	39
Kidney Dialysis.....	40
MAJOR MEDICAL EXPENSE BENEFITS.....	41
General Hospital.....	41
Skilled Nursing Facility (SNF)/Outpatient.....	42
Private Psychiatric Facility.....	42
Substance Abuse Facility.....	42
Ambulatory Surgical Facility.....	43
Doctor Services.....	43
Surgery.....	43
Assistant Surgeon.....	43
General Anesthesia.....	43
Maternity Services.....	43
Inpatient Physician Visits.....	43
Other Physician Evaluation and Management Visits.....	44
Specialist Consultation.....	44
Second Surgical Opinion Consultation.....	44
Radiation Therapy.....	44
Diagnostic X-rays and Machine Tests.....	44
Diagnostic Lab and Pathology.....	44
Podiatry Services.....	45
Chiropractor Services.....	45
Outpatient Mental Health Care.....	45
Professional Nursing.....	45
Private Duty Nursing.....	45
Visiting Nurses.....	46
Nurse Midwife Services.....	46
Physical Therapy.....	46
Speech Therapy.....	46
Durable Medical Equipment.....	46
Prosthetics/Orthotics/Braces.....	47
Medical Supplies (Self-care Home Use).....	47
Ambulance.....	48
Professional or Hospital Owned Ambulance.....	48
Volunteer Ambulance.....	48
Chemotherapy.....	48
Blood Transfusions.....	48
Oxygen and its Administration (Self-Care Home use).....	49
Drugs and Medicines.....	49
MISCELLANEOUS PROVISIONS.....	49
Voluntary Sterilization.....	49

Artificial Conception	49
Dental Care.....	50
PRESCRIPTION DRUG EXPENSE BENEFITS	51
Covered Prescription Drug Expenses	51
Voluntary Generic Drug Substitution Program	51
When Another Plan is Primary	51
Participating Pharmacy.....	52
Copayments.....	52
Plan Identification Card.....	52
Obtaining Benefits.....	52
Nonparticipating Pharmacy.....	52
Mail Service for Maintenance Drugs	52
Mail Service Copayments	53
How to Use the Mail Service Pharmacy Program	53
Prescription Drug Expense Exclusions	53
SECTION V - MEDICARE INTEGRATION WITH PLAN BENEFITS	55
MEDICARE SECONDARY PAYER (MSP) CURRENT RULES	55
EFFECTS OF MEDICARE ON PLAN BENEFITS	56
Medicare Payment Integration.....	56
Not Enrolled in Medicare.....	56
Medicare Private Contract Options	56
Medicare HMO.....	56
ALLOWABLE FEES	56
SECTION VI - COORDINATION OF BENEFITS (COB).....	58
COB TERMS AND DEFINITIONS.....	58
ORDER OF BENEFIT DETERMINATION.....	60
Non-Dependent or Dependent	60
Child Covered under More than One Plan	60
Active/Inactive Employee	60
Continuation of Coverage	61
MEDICARE EFFECT ON THE ORDER OF BENEFIT DETERMINATION	61
COB EFFECT ON PLAN BENEFITS	61
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.....	62
FACILITY OF PAYMENT	62
RIGHT OF RECOVERY.....	62
EXAMPLES OF COB ORDER OF BENEFITS	62
SECTION VII - PLAN EXCLUSIONS.....	65
SECTION VIII - CLAIM SUBMISSION AND REVIEW PROCEDURES	72
HOW TO SUBMIT A MEDICAL CLAIM.....	72
Network Provider Claims	72
Hospital Inpatient or Outpatient Claims.....	72
Other Claim Submissions.....	72
TIME LIMIT ON CLAIM SUBMISSION.....	73
AUTHORIZATION TO PAY PROVIDER/BENEFIT ASSIGNMENT	73
HEALTH CLAIM INQUIRIES	74
CLAIM APPEALS PROCEDURES	74

LEGAL PROCEEDINGS.....	75
SECTION IX - OTHER PROCEDURES AND PROVISIONS	75
NOT A CONTRACT	75
VERIFICATION OF CLAIM INFORMATION.....	76
RIGHT OF EXAMINATION.....	76
INDEMNITY BENEFITS.....	76
MISREPRESENTATION/FRAUD.....	76
REFUND DUE TO OVERPAYMENT OF BENEFITS.....	76
RIGHT OF REIMBURSEMENT.....	76
Conditional Benefit Payment.....	77
Reimbursement Agreement.....	77
AMENDMENTS OR CANCELLATION OF THE PLAN/RIGHT TO DEVELOP GUIDELINES	78
CONFORMITY WITH LAW	78
SEVERABILITY.....	78
WAIVER AND ESTOPPEL.....	78
HEADINGS	78
SECTION X - DEFINITIONS	79

INTRODUCTION

The Bedford School District (also shown hereafter as District) is pleased to give you a copy of the Summary Plan Description (also shown hereafter as SPD) for the Bedford/Carmel Health Benefits for Bedford Central Schools. The preventive care, Hospital, major medical and prescription drug expense benefits shown in this Plan are available for eligible Employees, retirees of the District and their eligible Dependents. You should read this SPD carefully to acquaint yourself with its provisions for eligibility, enrollment, Coverage, filing a claim, and other important information.

PLAN IDENTIFICATION

Plan Name:	Bedford/Carmel Health Benefit for Bedford Central Schools
Plan Administrator:	Bedford Central School District
Plan Sponsor:	Bedford Central School District
Plan Effective Date:	January 1, 1999
Plan Year:	12 consecutive months starting January 1 and ending December 31
Claims Administrators:	
Medical Benefits	POMCO
Benefit Management Program:	POMCO
Prescription Drug Benefits:	Pharmaceutical Card System (PCS)

Please Note

This SPD updates and replaces previous publications showing Coverage for the self-funded Bedford/Carmel Health Plan, for Employees and retirees of the Bedford Central School District. This Plan is separate from the previous Plan known as Bedford/Carmel Health Benefits Plan. This Bedford/Carmel Health Benefit for Bedford Central Schools covers expenses Incurred on and after January 1, 1999.

*The pronoun you or your means an eligible and enrolled Employee or retiree of the Bedford School District. It also means a survivor or COBRA participant whose social security number is used for Plan enrollment. Terms throughout this SPD have been capitalized and are defined in **Section X - Definitions** to help you understand your Plan Coverage and benefits*

The Bedford Central School District has designed a Plan that provides health benefits for a broad range of medical services at the lowest possible cost for the Plan and its participants. A number of features have been included in this Plan to manage costs and to ensure that the Health Care Benefits are within Plan guidelines.

This SPD is a summary of the health benefits available for Covered Plan services and supplies. It shows your rights, obligations, and benefits under the Plan. The Master Plan Document of the Bedford/Carmel School District Plan for Bedford Central Schools, consisting of the SPD, the terms of the Plan, and any Amendments to the Plan, is maintained and on file with the Plan Administrator. This SPD is not intended to interpret, extend, or change the provisions of the Plan in any way. Due to negotiated changes or other changes, the SPD may not be fully current. Any Plan Amendments or changes shall become part of the Master Plan Document. The provisions of this Plan may only be determined accurately by reading the Master Plan Document. To the extent the SPD is inconsistent with the provisions of the Master Plan Document, the terms of the Master Plan Document will govern.

Benefits are self-funded and paid by the District. The District has engaged POMCO and PCS as claims administrators for the Plan.

1. Medical Benefits Claims Administrator. POMCO administers the Network Provider, Preventive Care, Hospital and Major Medical Expense Benefits. Claims should be mailed directly to POMCO for benefit determination. If you have any questions or concerns about Your Coverage, you can phone POMCO. Claim forms can be obtained from the District or POMCO. Refer to **Section VIII-Claim Submission and Review Procedures** for details on how to submit a claim.

POMCO
P.O. Box 6329
Syracuse, NY 13217-6329
Phone Toll-free 1-800-234-9862

2. Prescription Drugs Claims Administrator

a. Pharmacies. Pharmaceutical Card System (PCS) administers your benefits for prescription drugs. Pharmacy claims should be mailed directly to PCS for benefit determination. If you are using a Nonparticipating Pharmacy, you must file your own claim. Claim forms can be obtained from the District Benefits Office, from POMCO or from PCS. Refer to **Section IV - Covered Services** under *Prescription Drug Expense Benefits* for details.

b. Mail Service Drugs Claims Administrator. Mail Service Drug benefits are administered through PCS. You can obtain a long-term supply of maintenance drugs directly from them. The form to initiate this program can be obtained from the District Benefits office. Any questions or concerns about the program can be directed to the PCS Customer Service Unit phone # 1-800-966-5772. Refer to **Section IV - Covered Services** under *Prescription Drug Expense Benefits* for details.

3. Benefit Management Program Administrator. POMCO administers the Benefit Management Program. You are required to phone the POMCO Benefit Management Unit to meet requirements of the Benefit Management Program. Failure to comply with the requirements of this program could result in reduction of your benefits. Refer to **Section III - Benefit Management Program** for full details of program requirements. Mandatory phone calls are required. You must call POMCO:

- a. Before a scheduled admission as an Inpatient to a Hospital or other facility, or **within 48 hours** after an emergency or urgent admission;
- b. If maternity stays exceed **48 hours** after normal delivery or **96 hours** after cesarean section;
- c. If newborn care exceeds **96 hours** after birth; or
- d. Before home health care services begin.

Phone: POMCO Benefit Management Unit Toll Free: 1-800-766-2648

This is a 24-hour service. If you wish to talk to the POMCO nurses, you must call between 8:30 A. M. and 4:30 P. M. on normal business days. Otherwise provide complete information as requested by voice mail message.

Please Note

*All claims are subject to review to decide if services are Covered by Plan limitations. You must comply with requests for additional medical documentation as deemed necessary to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. **Treatment decisions are independent from payment decisions.** The patient's Physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in or excluded from Coverage under this Plan.*

SECTION I – SUMMARY OF BENEFITS

The benefits shown in this SPD are available to enrolled and eligible Employees, retirees and their enrolled and eligible Dependents (Covered Persons). Please refer to **Section II - Eligibility and Enrollment** for eligibility requirements.

A. SUMMARY

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered service, please refer to **Section IV - Covered Services**, **Section VII - Plan Exclusions**, and **Section X - Definitions**.

1. **Network and Out-of-Network Expenses.** Network means services and supplies rendered and billed by the POMCO/MultiPlan Allied Network (Network) Participating Providers (Network Providers). Out-of-Network means services and supplies rendered and billed by Nonparticipating Providers. You or your Dependents may choose either for medical care. However, the Network Providers have an agreement with POMCO to bill according to an established fee schedule. Usually, these fees result in savings for both you and the Plan. Please refer to **Section IV - Covered Services** under *Participating Provider Network Program* for details.
2. **Full Benefits.** The terms Full Benefits or Full Network Benefits mean 100% of Allowable Fees.
3. **Allowable Fees**
 - a. **Out-of -Network Providers.** Allowable Fees mean the Usual, Customary and Reasonable (UCR) Charges for Covered medical services or supplies rendered and billed by a Covered Nonparticipating or out of Network Provider. The services or supplies must be Incurred by a Covered Person while eligible for Plan Coverage. If you or your Eligible Dependents use an out of Network Provider, you will be responsible for the payment of charges that are more than the UCR allowance, if any, plus applicable Plan Deductibles and Percentage Copayment amounts. Out-of-Network means services or supplies rendered by a Provider who does not have an agreement with the Participating Provider network.
 - b. **Network Participating Providers.** Allowable Fees mean the scheduled Network allowance for Covered medical services or supplies rendered and billed by Providers who participate in the POMCO/MultiPlan Allied Network, a national network of Participating Providers. The services or supplies must be Incurred by a Covered Person while eligible for Plan Coverage. The Network Provider has an agreement with the Claims Administrator to bill for Covered Services or Supplies according to the Network schedule of allowances. This allowance is considered payment in full, unless Plan otherwise limits benefits, with the exception of Network Copayments.

Please Note

*LabOne, a fully accredited and certified laboratory has been engaged by the Plan Administrator to provide lab services under the Lab Card benefit. Use of this service is voluntary by you and/or your Eligible Dependents. To use this Provider, you or your Dependent must present your Plan identification card and ask your Physician to utilize their services for lab work. For details on the Lab Card benefits, see **Section IV - Covered Services** under *Participating Provider Program (PPO)*.*

A directory of Participating Providers is available at the District Benefits Office or you may call POMCO for information on Providers near you. You may also access the POMCO/MultiPlan Allied Network directory on the POMCO website: www.pomcoplus.com.

If this Plan is primary and you or your Eligible Dependents use a Network Provider for Covered Services or Supplies, you will be responsible for applicable Network Copayments. The Plan will pay the balance of the Network allowance directly to the Network Provider. As the Network allowance is generally lower than the UCR allowance, choosing a Network Provider for medical care can result in cost savings for you and the Plan.

If this Plan is secondary to another health plan or to Medicare, Network benefits are not available. Benefits will be based on UCR charges and applicable Plan Deductible and Percentage Copayments. See **Section V - Medicare Integration with Plan Benefits** and **Section VI - Coordination of Plan Benefits** for details on the order of benefit determinations when two or more health plans are involved.

B. PREVENTIVE CARE EXPENSE BENEFITS

Preventive Covered Services	Network	Out-of-Network
Network Copayment (Amount of Network allowance paid by Enrollee)	\$10.00 per Provider per type of service. Copayment Limit: \$30.00 per Covered Person each event (all services by same Provider same day)	Does not apply.
Well Child Care	<i>Benefits provided for eligible children from birth to age 18 (under age 18). Includes age appropriate well child care, usual related tests and immunizations. Out-of-Network Benefits count toward Major Medical Calendar Year/Lifetime Benefit Limit.</i>	
Routine Physician Nursery Care	Full Network Benefits up to maximum of \$75.00 for nursery care. Full Network Benefits for circumcision.	Full Benefits up to maximum benefit of \$75.00 for combination of nursery care and/or circumcision.
Well Child Care	Network Copayment applies. Frequency based on age.	<i>Allowable Fees limited to Network allowance. The Plan pays the balance of Network allowance, after Network Copayment. You pay the Network Copayment for out of Network Providers, and charges more than Network allowance.</i> Frequency based on age.
Adult Routine or Well Care	<i>Benefits are provided for limited routine care services not due to Illness or Injury. Covered expenses are not subject to the Plan Deductible but benefits count toward Major Medical Calendar Year/Lifetime Benefit Limit. Limits apply to any combination of Network and Out of Network Providers.</i>	

Preventive Covered Services	Network	Out-of-Network
<p>Adult Routine Physical (Includes usual related tests, including routine hearing screening).</p>	<p><i>Coverage is available only for eligible Employees, Spouse and Dependent Children. This benefit is not available to Retirees and their Dependents.</i></p> <p>After Network Copayment, Plan pays balance of Network allowance up to \$200.00 Coverage is limited to once every two consecutive Calendar Years. <i>Network Providers may balance bill up to Network Allowance.</i></p>	<p>No Deductible. Plan pays 80% up to benefit maximum of \$200.00. Coverage is limited to once every two consecutive Calendar Years.</p>
<p>Routine cervical Pap tests and related cervical exam</p>	<p>Network Copayment applies. Limited to once per 12 consecutive months for Covered female age 18 or older.</p>	<p>Not a Benefit.</p>
<p>Routine Mammography (age 18 or older)</p>	<p><i>Frequency based on age and medical history.</i> <i>Hospital Outpatient Charges:</i> You pay first \$25.00 then balance of Allowable Fees paid in full. <i>Other Providers:</i> Network Copayment applies.</p>	<p><i>Frequency based on age and medical history.</i> <i>Hospital Outpatient Charges:</i> You pay first \$25.00 then balance of Allowable Fees paid in full. You could be billed for charges more than UCR allowance. <i>Other Providers:</i> Covered under Major Medical Expense Benefits.</p>
<p>Prostate Cancer Screening Program</p>	<p>The District offers a special program for routine prostate cancer screening exams and related tests. The District will schedule this program once a year. You will receive an annual announcement showing the scheduled dates, parameters of the program, and a list of the participating healthcare Providers that have been engaged to render the program services.</p>	

C. HOSPITAL EXPENSE BENEFITS (HEB)

Maternity care is Covered the same as any other Illness including, but not limited to, childbirth and other termination of Pregnancy. According to the Newborns' & Mothers' Health Protection Act, a federal law effective for this Plan as of January 1, 1998, a health Plan, or its managed care or benefit management program, that offers coverage for Hospital stays in connection with childbirth cannot limit that coverage to less than a 48-hour Hospital stay following an uncomplicated normal delivery; or less than a 96-hour Hospital stay following a cesarean section delivery. In addition, the health Plan cannot restrict benefits for any portion of the required minimum stays in a manner that is less favorable than the benefits provided for any preceding portion of the stay. Additionally, this Plan will abide by a state law that provides more favorable maternity stays when such laws affect this Plan.

Hospital Expense Benefits Covered Services	Network and Out-of-Network Benefits/Limits
Hospitals and other Facilities, Agencies	<p>Most Inpatient admissions and home health care require a mandatory phone call to the Claims Administrator. See Section III - Benefit Management Program for details.</p> <p>Benefits are provided for services and supplies rendered and billed by a Covered Hospital, facility or agency for the treatment of an Illness or Injury. Inpatient private room will be allowed at the Average Semi-Private Room Rate. Benefit limits are per Covered Person. Benefit Limits are cumulative for Network and Out-of-Network Providers. Note: If you use an Out-of-Network Provider you could be responsible for payment of charges that are more than the determined UCR allowance.</p>
General Hospital	
<p>Hospital Inpatient Care Medical or Surgical Care, Maternity Care</p>	<p>Full Benefits up to 365 benefit days per Spell of Illness. Full Benefits up to 365 benefit days per Spell of Accidental Injury, does not count toward Spell of Illness limit.</p>
<p>Psychiatric Care</p>	<p>Full Benefits up to 120 days per Calendar Year. Benefit days count toward 365 days per Spell of Illness limit shown above.</p>
<p>Hospital Outpatient Care</p>	<p>Charges must be billed by the Hospital for its services and supplies. Physician charges are considered separately. <i>Enrollee Copayment shown below is paid per Covered Person for each Provider per service date. Copayments do not apply if the patient is admitted to the same Hospital from the Outpatient department.</i></p>

Hospital Expense Benefits Covered Services	Network and Out-of-Network Benefits/Limits
Emergency Care <i>Accidental Injury</i> <i>Sudden and Serious Illness</i> Surgery	Full Benefits when Covered Hospital services rendered within 72 hours after the accident. Full Benefits when Covered Hospital services rendered within 12 hours after the onset of acute symptoms. \$25.00 per visit Copayment then balance of Allowable Fees paid in full.
Preadmission Testing	\$25.00 per visit Copayment then balance of Allowable Fees paid in full.
Kidney Dialysis	Full Benefits
Diagnostic X-ray Lab and Machine Tests	\$25.00 per visit Copayment then balance of Allowable Fees paid in full. See separate benefit for preventive mammography.
Radiation Therapy	Full Benefits
Physical Therapy	\$25.00 per visit Copayment 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.
Other Covered Hospital Services and Supplies	Coverage is available under Major Medical Expense Benefits.
Certified Birth Center	Covered the same as General Hospital for services and supplies related to maternity care.
Skilled Nursing Facility Inpatient	Full Benefits up to 150 benefit days per Spell of Illness. Additional Coverage is not available under Major Medical Expense Benefits.
Ambulatory Surgical Facility	Covered under Major Medical Expense Benefits
Kidney Dialysis in office, home or Medicare Certified Free Standing Kidney Dialysis Facility.	Full Benefits for services and supplies related to kidney dialysis procedure. Professional evaluation and management of the Illness is Covered separately as office visit or Hospital visit.
Home Health Agency	Full Benefits up to 365 benefit days per Spell of Illness. Three visits by members of home care team equals one benefit day. Benefit days count toward the Hospital 365 day per Spell of Illness .
Hospice Agency	Full Benefits for an Approved Plan of Care.

Hospital Expense Benefits Covered Services	Network and Out-of-Network Benefits/Limits
Alcohol Abuse Facility or Agency	Plan of Care requires Coverage approval by the Claims Administrator. Treatment Plan must be sent before care begins or within 10 calendar days after treatment begins. Substance (other than alcohol) Abuse Covered under Major Medical Expense Benefits.
Inpatient Alcohol Rehabilitation	Full Benefits for an Approved Plan of Care up to 7 weeks per confinement. Not more than 7 weeks per Calendar Year. Additional Coverage <i>is not</i> available under Major Medical Expense Benefits.
Outpatient Alcohol Rehabilitation	\$10.00 Copayment 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.
Ambulance	Hospital Owned: Full Benefits when billed by the owner Hospital for emergency transportation to the nearest Hospital for Outpatient care or emergency admission. Other Ambulance Services: Coverage available under Major Medical Expense Benefits.

D. MAJOR MEDICAL EXPENSE BENEFITS

Deductibles, Copayments and Benefit Maximums
<i>Unless shown otherwise, the Plan Deductibles and Percentage Copayments apply to Out-of-Network Allowable Fees. The Network Copayments apply only when shown for Covered Network services.</i>
<p>Calendar Year Deductible: The part of the Allowable Fees that the participant must pay each Calendar Year. Benefits are based on the balance.</p> <p>Percentage Copayment: The portion of Allowable Fees paid by the Plan (usually after Deductible is taken).</p> <p>Network Copayment: The portion of the Network Allowable Fee paid by the Employee. This Copayment does not count toward Major Medical Deductibles or Percentage Copayments.</p> <p>Per Event: Means all services rendered by the same Provider on the same day.</p> <p>Calendar Year/Lifetime Benefit Maximum: The most the Plan will pay per Covered Person for Major Medical Expense Benefits.</p>

Major Medical Expenses	Network	Out-of-Network
Calendar Year Deductible	Does not apply.	Individual: \$250.00 per Covered Person. Family Limit: \$750.00 maximum Calendar Year Deductible for three or more Family Members.
Common Accident Deductible	Does not apply.	Limit per family: \$250.00 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 \$3750.00 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 \$750.00.
Network Copayment <i>Does not apply when Medicare or another health plan is primary payer.</i>	\$10.00 per Provider per service type. Copayment Limit: \$30.00 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.

Major Medical Expenses	Network	Out-of-Network
<p>Benefit Maximum</p>	<p>Calendar Year: \$100,000.00 actual Major Medical Expense Benefits paid per Calendar Year for each Covered Person. Lifetime: \$1,000,000.00 actual Major Medical Expense Benefits paid per each Covered Person’s Lifetime for expenses Incurred while Covered under the Plan. Restoration of Maximum Limits: Once Major Medical Expense Benefits of \$1000.00 or more have been paid for a Covered Person, paid benefits may be restored if satisfactory evidence of good health for that person is presented to the Plan Administrator. The District can provide details concerning this restoration feature.</p>	
<p>Major Medical Covered Expenses and Benefit Limits</p>		
Major Medical Covered Services	Network Benefits/ Limits	Out-of-Network Benefits/ Limits
<p>General Hospital Outpatient and Inpatient after Hospital Expense Benefits exhausted.</p>	<p>80%, after Deductible, for Covered Services after Hospital Expense Benefits exhausted. Network and Out-of-Network expenses count toward the Percentage Copayment Limit. Note: Network Providers can balance bill up to negotiated allowance. See separate limit for psychiatric Inpatient Care shown below.</p>	
<p>Psychiatric Inpatient Hospital and Private Facility</p>	<p>80%, after Deductible, for Covered Services after Hospital Expense Benefits exhausted. Limited to 30 Inpatient benefit days per Calendar Year for any combination of Hospital and private facility admissions and for any combination of Network and Out-of-Network Providers. Network and Out-of-Network expenses count toward the Percentage Copayment limit. Note: Network Providers can balance bill up to negotiated allowance.</p>	
<p>Psychiatric Outpatient</p>	<p>No Copayment. Plan pays up to \$40.00 of Network allowance per visit for care by licensed psychiatrist or psychologist. No other mental health Providers are Covered. Provider may balance bill up to Network allowance.</p>	<p>80%, after Deductible up to benefit limit of \$40.00 per visit for Licensed psychiatrist or psychologist. No other mental health Providers are Covered. Balance does not apply to Percentage Copayment limit.</p>
<p>Substance Abuse Facility</p>	<p><i>Plan of Care requires Coverage approval by the Claims Administrator. Treatment Plan must be sent before care begins or within 10 calendar days after treatment begins. Alcohol Covered under Hospital Expense Benefits shown previously.</i></p>	

Major Medical Covered Services	Network Benefits/ Limits	Out-of-Network Benefits/ Limits
Substance Abuse Inpatient	80%, after Deductible. Up to 7 weeks per confinement and no more than seven weeks in a Calendar Year.	
Substance Abuse Outpatient	<i>After Network Copayment</i> , Plan pays balance of Network allowance 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 whether or not the enrolled Family Member is receiving care.)	80%, after Deductible for an approved Plan of Care. Up to 60 visits per Calendar Year for any combination of Network or Out-of-Network Providers. (20 of these visits may be used for enrolled Family Member counseling. Five of the 20 may be used whether or not the enrolled Family Member is receiving care.)
Ambulatory Surgical Care Facility	80%, after Deductible.	
Other Medical/ Surgical Office Services	<i>Office visits include medical management, therapy and surgical services rendered in any Provider's office (or clinic). For example: by Physicians, chiropractors, podiatrists, physical therapists, et. Al. Diagnostic Tests are Covered separately.</i>	
Office Visits	Network Copayment.	80%, after Deductible.
Specialist Consultations Outpatient	Network Copayment.	80%, after Deductible.
Inpatient	Full Network Benefits. Limit: One consultation per specialty for each Hospital confinement.	80%, after Deductible.
Mandatory Second Opinion Consultation (Mandated by Benefit Management Program)	Full Network Benefits.	Full Benefits. Deductible and Percentage Copayment do not apply.
Voluntary Second Opinion (through Benefit Management Program)	Full Network Benefits.	Full Benefits when obtained through Benefit Management Program. Deductible and Percentage Copayment do not apply.

Major Medical Covered Services	Network Benefits/ Limits	Out-of-Network Benefits/ Limits
Second Surgical Opinion (Not obtained through Benefit Management Program)	Network Copayment applies when not obtained through the Benefit Management Program. Plan Limit: Initial and one additional second opinion if the first opinion does not agree Surgery is necessary.	80%, after Deductible when not obtained through Benefit Management Program. Plan Limit: Initial and one additional second opinion if the first opinion does not agree Surgery is necessary.
Surgery	Full Network Benefits.	80%, after Deductible.
Inpatient Physician Visits	Full Network Benefits.	80%, after Deductible.
General Anesthesia	Full Network Benefits.	80%, after Deductible.
Chiropractic Care	Network Copayment Applies. Benefits are limited to \$750.00 for any combination of Network and Out-of-Network Providers.	80%, after Deductible. Benefits are limited to \$750.00 for any combination of Network and Out-of-Network Providers.
Chemotherapy	Full Network Benefits.	80%, after Deductible.
Diagnostic Tests (X-rays, Labs and Machine Tests)	Network Copayment Applies. Per series of each type of diagnostic test (x-ray, lab or machine test) is considered one type of service. Network Copayment is waived for lab services when obtained through LabOne.	80%, after Deductible.
Durable Medical Equipment	<i>A phone call is required before DME rental or purchase when costs are expected to exceed \$100.00. Refer to Section III - Benefit Management Program under Durable Medical Equipment Review for details.</i>	
	Full Network Benefits.	80%, after Deductible.
Ambulance Professional or Hospital Owned Volunteer	80%, after Deductible. <i>See Hospital Expense Benefits for Hospital owned ambulance to nearest Hospital for Outpatient services or to owner Hospital when patient admitted.</i> Full Benefits up to maximum of \$25.00 per Calendar Year. Proof of donation must be submitted. <i>Deductible and Percentage Copayment do not apply.</i>	
Professional Nursing	<i>Plan excludes Inpatient private duty nursing. The first 48 hours of Covered care per Calendar Year is excluded for Private Duty Nursing.</i>	

Major Medical Covered Services	Network Benefits/ Limits	Out-of-Network Benefits/ Limits
Private Duty Nursing	Full Network Benefits up to benefit limit of \$30.00 per hour for Approved Care following the first 48-hour exclusion. Provider may balance bill up to Network allowance.	80%, after Deductible for Allowable Fees following the first 48-hour exclusion. Allowable Fees are limited to \$30 per hour for Approved Care. Charges more than \$30.00 per hour are not Covered.
Visiting Nurse	\$10.00 Copayment.	80%, after Deductible.
Nurse Midwife	Same as Physician and other Providers. For example, \$10.00 Copayment for office visits. Full Network Benefits for Inpatient services. Paid on same basis as Physician for office visits and Surgery.	80%, after Deductible.
Wig/Hairpiece	Plan pays up to \$250.00 for the initial wig or hairpiece ordered by Doctor for hair loss due to chemotherapy or radiation therapy. Limited to one wig/hairpiece per Lifetime.	
All Other Covered Services	Network Copayment applies.	80%, after Deductible.

E. PRESCRIPTION DRUG EXPENSE BENEFITS

Secondary Coverage: If this Plan is secondary, Coverage is not available under this benefit.

Primary Coverage: If this Plan is the primary health Coverage according to the Coordination of Benefits provision, then the Prescription Drug Expense Benefits shown below apply. Prescription Drug Expense Benefits are separate from Medical Expense Benefits and do not apply to the Medical Expense Benefits Deductibles, Copayments or benefit maximums. For details, refer to **Section IV - Covered Services** under *Prescription Drug Expense Benefits*.

Covered Services	Participating Pharmacy	Nonparticipating Pharmacy
Pharmacy	Allowable Fees are limited to the PCS 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 PCS to receive Plan benefits.	
	Limited to 34 days supply or 100-dosage unit, whichever is greater.	
	Drug Copayments: <i>Specified Drugs:</i> \$7.00 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> \$ 3.00 for each prescription or refill. <i>Brand Name:</i> \$ 10.00 for each prescription or refill.	
Mail Order Pharmacy	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> \$1.00 for each prescription or refill. <i>Brand Name:</i> \$5.00 for each prescription or refill.	Not a Benefit.

F. POTENTIAL CAUSES FOR BENEFIT REDUCTION

1. Medicare Effect on Plan Benefits

You or your Dependent should enroll for Medicare upon eligibility or when Medicare is considered primary coverage. Failure to enroll in Medicare when Medicare is primary payer could result in significant reduction or denial of your health benefits. You could be responsible for the payment of all or most of your health expenses.

Medicare payments could reduce your benefits if Medicare is considered the primary coverage according to Medicare Secondary Payer rules. This reduction will apply whether or not the person eligible for Medicare is actually enrolled in Medicare. Refer to **Section V - Medicare Integration with Plan Benefits.**

2. **Coordination of Benefits Effect on Plan Benefits.** Your benefits could be reduced if you or your Eligible Dependents are covered by more than one health plan. Refer to **Section VI - Coordination of Benefits.**
3. **Benefit Management Program.** Your benefits could be reduced if you fail to follow the requirements of the Benefit Management Program. Refer to **Section III - Benefit Management Program.**

Please Note

*All claims are subject to review to decide whether services are Covered according to Plan limitations. You must comply with requests for additional medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. **Treatment decisions are independent from payment decisions.** The patient's Physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in or excluded from Coverage under the Plan.*

SECTION II – ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY FOR PLAN ENROLLMENT

Rules concerning eligibility for Plan enrollment are established by collective bargaining agreements and by established policies of the Bedford School District Board of Education, as amended. The following section provides a description of eligibility rules in effect at the time this SPD is published. However, the content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The District Benefits Office can provide full details of the District's current eligibility requirements for Plan enrollment.

1. **Active Employees/Retirees.** An active Employee is eligible for Plan enrollment when meeting the minimum requirements established by the District and/or negotiated bargaining agreements. A retiree is eligible for Plan enrollment when he or she is retired in accordance with the requirements of the retirement program established by the District and/or negotiated bargaining agreements.
2. **Dependents.** The following Dependents are considered eligible as Dependents for enrollment in family Coverage:
 - a. **Legal Spouse** of an Employee or retiree. (A legally separated Spouse may be enrolled in the Plan, but a divorced Spouse is not eligible). The District may require proof of marriage.
 - b. **Your Unmarried Children** who are:
 - 1) Under 19 years of age. Your newborn child is eligible from the moment of birth **if** enrolled in family Coverage within **30 days** after date of birth. An unmarried child whose 19th birthday occurs during school vacation period will continue to be eligible for benefits, provided the child is enrolled in a school and is anticipating full-time student status at the end of the vacation period.
 - 2) Over 19 years of age, but under age 25, who receive more than half their support from the Employee and are full-time matriculating students at an accredited secondary school, college or university. Time spent in the U.S. Military service, not to exceed four years, may be deducted from the Dependent's age for the purposes of establishing eligibility.

In the event your Dependent child, who is a full-time student, is disabled and is granted a medical leave by the school he or she is attending, benefits will continue for a maximum of 12 calendar months following the month in which the child withdraws from school. If the end of the 12 calendar months occurs during a vacation period, benefits will be extended to the beginning of the next regular semester.

In the event your unmarried Dependent child between the ages of 19 and 25, who previously was not eligible for benefits or had benefits ended, returns to a full-time student status, he or she may be reinstated to family Coverage effective the actual date the student commenced full-time attendance at the high school or an accredited institute of higher learning.

- 3) Age 19 years or older and incapable of self-support because of mental or physical disability and became so disabled before reaching age 19. The eligibility of such a Dependent should be established as early as possible. This should be done at the time of your initial enrollment if the child is age 19 or older at that time. If the child has not yet attained age 19 at the time you first enroll in the program, eligibility for continued benefits should be established at the time of his or her 19th birthday.

To obtain Plan Coverage for incapacitated Dependents or full-time students, you may be required to document, at least annually, appropriate certification of this fact to the District Benefits Office. Failure to provide the required information when requested will result in that child being removed from enrollment and eligibility for benefits until proof is provided which supports continued eligibility for Plan enrollment.

c. Child Definition - Child or children mean:

- 1) The Employee's own birth child or legally adopted child, whatever the child's place of residence or support provided;
- 2) Any stepchild of the Employee who permanently resides in the Employee's home.
- 3) Any other child supported by the Employee or the Spouse of the Employee and permanently residing in the Employee's home, provided the support and residence commenced before the child reached age 19; or
- 4) Any unmarried child placed for adoption before the child reaches age 18. The term placed for adoption means a child placed in the Employee's home and the Employee's assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. This eligibility ends when such legal obligation terminates. Proof of pre-adoption status will be required by the District Benefits Office to establish eligibility. Once the child is legally adopted, he or she retains eligibility as a legally adopted child as shown above.
- 5) Pre-adoptive newborn from the moment of birth under a family Plan when all of the following conditions are met:
 - a) You enroll the child, you intend to adopt, in a family Plan within 30 days of the birth and applicable family Contribution is made;
 - b) You take physical custody of the child upon discharge from the Hospital or Birth Center; and
 - c) Within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under New York State or Domestic Relations Law or similar state laws when filed outside NY state.

Coverage will not be provided for initial Inpatient treatment of a pre-adoptive newborn, if the child's biological parent has health coverage for that care. Also, if a notice of revocation of the adoption has been filed, or a biological parent revokes consent to the adoption, Plan Coverage will not be provided. If Plan benefits were paid for a pre-adoptive newborn, whose adoption was revoked, the Employee may be requested to reimburse those Plan payments.

Please Note

Documentation of the Dependent status with the District Benefits Office will be required. Criteria of support will be deemed to have been met if the Employee contributes at least 50 percent to the support of the Dependent and that Dependent qualifies as an exemption on the most recent Federal income tax return filed by the Employee.

3. **Qualified Medical Child Support Orders.** Federal Law requires the Plan, under certain circumstances, to provide Coverage for your children when you or your Spouse divorce or separate. The law also provides for children born out of wedlock. The Plan must comply with qualified medical child support orders (QMCSO) that relate to Plan benefits. QMCSO means orders, judgement, settlement, or a decree issued from a court of competent jurisdiction, magistrates or other officials with the power to issue a QMCSO, pursuant to a state's domestic laws, that requires the Plan to provide Coverage for your child. This Coverage is provided even if you no longer have custody and even if you would not have chosen to cover the child under your health Plan. The child's custodial parent, legal guardian or state agency can apply for Coverage even if you don't. If the Plan receives a QMCSO, it will provide immediate enrollment. This means the child identified will be included under Your Coverage, as required according to the QMCSO requirements. You will be required to pay any

added monthly participation costs for the child's enrollment. You will receive written notification and be provided with further information about the QMCSO rules if the Plan receives an order that applies to you.

4. Survivor Dependent Eligibility

Should you die, your enrolled Dependents should contact the District Benefits Office for complete details concerning eligibility and costs for Coverage under this rule.

If an active Employee or retiree dies, his or her survivor Dependents who are enrolled in his or her family Coverage will continue to be eligible for three months without participation costs. After three months, this extension of eligibility continues to apply to survivors of eligible retirees or survivors of eligible Employees **who have completed at least ten years of active service with the District**. To be Covered, the survivors must request enrollment within 90 days after the death of the Employee or retiree. **If enrollment is not made within 90 days, eligibility under this rule is not available.** This Coverage ends for the Spouse when he or she remarries. For survivor children, Coverage ends when they otherwise no longer meet the definition of Dependent children. For example, reach limiting age or no longer a student. If survivors are not eligible for this extension or if Coverage ends under this rule, they could be eligible for *Continuation of Coverage under COBRA* shown later in this section.

5. Leave of Absence

The District Benefits Office can provide full details concerning your rights for Plan Coverage during an approved Leave of Absence.

You may retain your Plan individual Coverage or family Coverage while you are absent from work for an approved Leave of Absence. This continuation is not automatic. You must apply for continuation before your Leave of Absence starts. To remain eligible during a Leave of Absence without pay, you must remit your designated participation Contribution, if any, to the District each month on a timely basis. The District Benefits Office can answer questions concerning their requirements and provide details on your participation payments for Leave of Absence Plan continuation. You could be required to pay the total premium equivalent for Plan participation.

If you continue to be absent from work at the end of the approved Leave of Absence, Your Coverage under the Plan will end. However, you will be eligible to elect continuation of the Plan Coverage under COBRA. See *Continuing Coverage Under COBRA* shown later in this section.

If Your Coverage under the Plan ends while you are absent from work, it cannot be reinstated until you return to Active Employment. When you return to work, you must once more enroll in the Plan. The District Benefits Office can provide details on your effective dates of Coverage following Plan enrollment as a returning Employee.

Please Note

Under the Family and Medical Leave Act (FMLA) of 1993, a Federal law, eligible Employees are entitled to receive up to 12 weeks of unpaid leave in a 12 consecutive month period for certain family and medical reasons. If you are on an FMLA Leave of Absence, you may continue Plan Coverage by paying your monthly designated participation Contribution, if any, for Individual or Family Coverage. Plan continuation will be according to the FMLA law, as amended. The District Benefits Office can provide details of your rights under the FMLA and your costs to continue Coverage while on FMLA Leave of Absence.

B. ENROLLMENT

The Bedford School District can provide forms and details for enrollment options and your participation costs. Failure to report enrollment changes could result in Plan benefit overpayment. Should this happen, the District could request that you reimburse the Plan up to the benefit overpayments.

Enrollment in the Plan is not automatic. You are required to enroll yourself and your Dependents. You must meet the District's eligibility requirements. Employees must be Actively Employed at the time of enrollment. Plan participation costs are based on the type of Coverage you choose. Plan Coverage options are as follows:

1. **Individual Coverage.** Only the Employee, retiree, survivor Spouse, or a COBRA participant is enrolled. Benefits will be paid only for the person enrolled even if other Family Members meet eligibility requirements.
2. **Family Coverage.** Employee or retiree and one or more of his or her eligible Dependents are enrolled. (includes COBRA participants enrolled in family Coverage). Benefits are paid only for Family Members enrolled in the Plan even if other Family Members meet eligibility requirements.
3. **Enrollment Changes.** It is your responsibility to apply for any enrollment changes including:
 - a. Adding a newly acquired Spouse or Dependent child;
 - b. Adding an existing Spouse previously enrolled as an Employee;
 - c. Adding a previously eligible but non-enrolled Spouse or Dependent child;
 - d. Changing from individual Coverage to family Coverage any time you acquire a Spouse or Dependent child or elect to enroll a previously eligible but non-enrolled Spouse or Dependent child;
 - e. Changing from family Coverage to individual Coverage when you no longer have eligible Dependents or any time you no longer wish to provide Coverage for eligible Dependents;
 - f. Changing from two individual enrollments to one family Coverage or from one family Coverage to two individual enrollments when you or your Spouse are both eligible as Employees under this health Plan;
 - g. Changing or adding a new Dependent or removing an existing Dependent from family Coverage; or
 - h. Reporting other health plan(s) and Medicare coverage information and changes.

C. EFFECTIVE DATES OF BENEFITS

You should consult with the District Benefits Office for full details concerning how the effective date of benefits will be established for you or your Eligible Dependents. The following are the general rules for effective dates of benefits:

1. **Employee/Retiree General Rules**
 - a. Each Employee in an eligible class, whose employment commenced on or before the effective date of the Plan or each eligible retiree shall be Covered on the effective date of the Plan or shall be eligible for

any amended changes of the Plan. **The eligible Employee must be Actively Employed on such effective dates. However, Plan Coverage begins no sooner than the first day of the month after the date of eligible employment.**

- b. If you enroll at the time of Active Employment, Plan Coverage begins on the first day of the month following the date of eligible employment; or
- c. If you enroll at the time of eligible retirement, retiree Coverage begins on your date of retirement; or
- d. If you fail to enroll within 30 days of eligible employment, Coverage begins no sooner than the first day of the month following the date the District Benefits Office accepts your late enrollment application. Exception: See *Special Enrollment Effective Dates* shown later in this section.

2. **Dependent.** Coverage for an eligible Dependent will become effective on the date the Employee becomes Covered if the Employee applies for such Dependent Coverage when enrolling in the Plan. If you fail to enroll an existing Covered Dependent at the time of your initial enrollment, Coverage begins no earlier than the first day of the month following the date the late Dependent(s) enrollment is accepted by the District Benefits Office. Exception: See *Special Enrollment Effective Dates* shown below.

3. **Special Enrollment Effective Dates**

- a. **Adding New Dependents.** Your biological newborn child is Covered under your individual or family Coverage without Plan enrollment for the first 30 days after the date of birth. However, you must enroll the child under the following rules for that child to be Covered beyond the first 30 days.

- 1) If you are enrolled in the Plan and acquire new Dependents, after your initial enrollment, and enroll the new Dependents within 30 days after the date the eligible Dependents are acquired, Plan Coverage for the new Dependent will begin on the date you acquired the Dependent, but no sooner than the applicable employment Waiting Period.
- 2) If you are not enrolled in the Plan when you acquire a Spouse, you may enroll yourself and your Spouse under family Coverage. If you acquire a newborn child, or a newly placed or adopted child (under Age 18), you may enroll yourself and/or your Spouse and the newly acquired newborn child, newly placed for adoption or adopted child under family Coverage. For Coverage to be effective on the date you acquired the new Dependent, you must enroll within 30 days after the date of marriage, birth, placement for or adoption, whichever applies. This immediate Coverage rule does not apply to children existing at the time of your initial eligibility.
- 3) If you have individual or no Coverage at the time you enroll your new Dependents in family Coverage, you will be required to pay the full monthly participation costs, if any, for family Coverage beginning with the month in which the Dependent was acquired.
- 4) If you fail to enroll an eligible Dependent within 30 days from the date such Dependents were acquired, the new Dependent will be considered a late entrant. The Effective Date of Coverage will generally be the first day of the month after the date the District Benefits Office accepts your late enrollment application. The District Benefits Office can give you details concerning their established late enrollment rules.

- b. **Cancellation of Another Health Plan.** Eligible persons who did not enroll themselves and/or their Dependents at the time of initial disability because of coverage under another employer's plan may elect Coverage in this Plan to be effective on the date the other coverage canceled if the following conditions are met:

- 1) Person had health coverage at the time Coverage was previously offered; and

- 2) Person stated in writing at the time he or she declined enrollment in this Plan that the reason for declining was due to the other coverage; and
- 3) The other coverage was involuntarily terminated due to loss of eligibility; or exhaustion of the prior plan continuation of coverage; or cessation of employer Contributions to the other plan; or cancellation of coverage by the employer, insurer, or other issuing entity.
- 4) Person requests enrollment within 30 days after the date the other plan was canceled.

You must pay any applicable Contribution for individual or family Coverage to be eligible for benefits from the date the other plan coverage ended. Generally, persons who fail to enroll within 30 days after involuntary cancellation of the other plan will be Covered under this Plan no sooner than the first of the month following the date the District Benefits Office accepts the late enrollment application. The District can provide details concerning their effective date for enrollments after 30 days. This rule applies to persons who voluntarily cancel other plan coverage then seek late enrollment in this Plan. Voluntary cancellation includes, but is not limited to, cancellation or withdrawal from the other coverage by the Enrollee; removal of eligible Dependents from family Coverage by the Enrollee; or cancellation of coverage due to Enrollee fraud or nonpayment of required participation payments.

D. PLAN PARTICIPATION CONTRIBUTIONS

The District Benefits Office can provide details on your costs, if any, for Plan participation. If required, you must make your designated participation payments to maintain Plan eligibility. This is usually done by payroll deduction.

If you fail to authorize payroll deductions, you could be refused Plan Coverage. If you fail to make direct payment of required participation payments during a Leave of Absence or other available Plan Coverage continuation, Coverage could end for you and your Dependents.

E. END OF COVERAGE

Plan Coverage for you and your Eligible Dependents will end when you no longer meet the eligibility requirements of the Plan unless you become eligible under *Vested Employee Continuation of Coverage* shown below or you or your Dependents become eligible for *Continuation of Coverage under COBRA* shown later in this section. Exception: If you die, your survivor Spouse could be eligible to retain Coverage if you were an eligible retiree or vested Employee at the time of your death. Coverage for a Dependent ends when she or he no longer meets the Dependent eligibility requirements. However, the Dependent could be eligible to continue Coverage under COBRA. Eligibility and Coverage ends for the following unless enrollment under COBRA is elected:

1. You no longer meet employment eligibility due to reasons such as termination of employment, lay off, reduction in scheduled work hours, death, retirement, or change in job class. Coverage ends for you and your Eligible Dependents at the end of the month following the date you are no longer considered a Full-Time active Employee.
2. For failure to pay required Plan participation Contributions, Coverage ends for you and your Dependents at 12:01 a.m. on the first day of the month following the month for which you made your last participation payment. This also applies to an enrolled survivor Spouse.
3. Divorce of Spouse. Coverage ends for your ex-Spouse at 12:01 A. M. on the date the divorce or dissolution of marriage becomes final.
4. Dependent Child Coverage ends at 12:01 a. m. due to reasons such as:
 - a. The date your child marries.
 - b. The date your child, other than your biological or adopted child, is no longer living in your home and/or is no longer Dependent on you for most of his or her support or maintenance.
 - c. The date the child reaches age 19 and is not a full-time student or is not eligible as a disabled/handicapped child Dependent on the Employee for support.

- d. The date a disabled child age 19 or older is no longer disabled and/or dependent on the Employee for support.
- e. The date the child between ages 19 and 25 is no longer eligible as a full-time student.
- f. The date the full-time student reaches age 25; or
- g. The date a pre-adoptive child is removed from placement for adoption or the Employee is no longer legally responsible for most of the pre-adoptive child's support.

Coverage may be stopped immediately if you or your Dependents knowingly submits a claim, or allows any claim to be submitted with false information, or conceals any facts, that could affect the outcome of a claim determination. In this case, you or your Dependents cannot continue Coverage under COBRA.

F. VESTED EMPLOYEE CONTINUATION OF COVERAGE

The District Benefits Office can provide details concerning established rules and your costs for continuing Coverage while in vested status. This continuation of Coverage counts toward COBRA continuation periods.

1. **General Eligibility Rules for Vested Rights.** Employees, who end employment with the District before retirement age, may be eligible to continue Coverage both while in a vested status and, subsequently, during retirement. To be eligible, the Employee must have:
 - a. Satisfied the minimum requirements established by law for vesting his or her retirement allowance; and
 - b. Met all the minimum requirements except age for retiree Coverage. These requirements must have been met at the time you terminated employment. They must not be satisfied while you are in vested status or after your retirement allowance begins.
2. **Requesting Continuation of Coverage While in a Vested Status.** If you wish to continue this health Plan while you are vested, you must request continuation of Coverage from the District at the time employment is terminated. When the District authorizes continuation of Coverage, you will be required to pay your designated Plan participation costs from the date you are terminated. The District Benefits Office will assist you with the procedures required to keep Your Coverage in effect.

If Your Coverage ends because you made no request to continue Coverage, or failed to make participating payments during vested continuation Coverage, you will not be permitted to reinstate Your Coverage either during the remainder of your vested status period or after retirement. Once you have established eligibility to continue health Plan Coverage as a vestee, that eligibility will not be impaired by subsequent employment.

G. CONTINUING COVERAGE UNDER USERRA

The District Benefits Office must be notified, in writing (in advance when practical), should your eligible employment stop due to active United States Military Service. The District Benefits Office can provide full details concerning Employee rights under USERRA and the costs to continue Coverage while on active military duty. The following information is a brief summary. This Plan excludes health expenses resulting from Injuries or sickness incurred in or aggravated while on military duty. This Plan excludes any Illness or Injury caused by or resulting from military service.

The District must comply with the terms of the Uniformed Services Employment and Reemployment Rights Act (USERRA), a federal law. This law gives Employees certain rights concerning employment and health continuation should they meet the USERRA requirements. In general, eligible Employees whose Coverage would stop due to active United States Military Service have the right to continue Plan Coverage for up to 18 months or for the period of military service (whichever is shorter). To maintain Coverage, the Employee may be required to pay a monthly participation payment up to 102% of the full premium equivalent for individual or family Coverage. However, if the active service is less than 30 days, he or she will not be required to pay more than the normal participation contribution, if any. In addition, eligible Employees are entitled to immediate eligibility for Plan enrollment and Coverage when he or she meets the requirements of USERRA. Should you return to work when military service ends, the District Benefits Office can provide full details concerning your eligibility for immediate enrollment and Plan Coverage according to USERRA regulations.

H. CONTINUING COVERAGE UNDER COBRA

Please contact the District Benefits Office if you have any questions or concerns regarding COBRA Coverage requirements. Administration of this provision will be according to Federal COBRA regulations as amended.

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), a federal law, provides the opportunity for Enrollees or participants of the Plan to continue health Coverage that would otherwise end. The following statements are intended to summarize your rights and obligations currently in effect according to this law and its amendments. ***Both you and your Spouse should take the time to read this provision carefully.***

1. Qualifying Events and Notification

You or your Dependents who cease to meet the Plan eligibility requirements must notify the District Benefits Office of a divorce, legal separation, child losing eligibility status or other qualifying event. This Notice must be in writing sent to the District Benefits Office within 60 days after the event. If notice not given in 60 days, Coverage cannot be continued.

Employees or eligible Dependents may elect to continue health Plan Coverage that would otherwise end because of one or more the following conditions (COBRA qualifying events):

- a. Voluntary or involuntary termination of your employment with the District, except when termination due to gross misconduct (Employee and/or Spouse or Dependent children may elect to continue);
- b. Reduction of Employee work hours or change in job class (Employee and/or Spouse and Dependent children may elect to continue);
- c. Retirement (Employee and/or Spouse or Dependent children may elect to continue);
- d. Death of an Employee (Spouse or Dependent children may elect to continue);

- e. Divorce or Dissolution of marriage (ex-Spouse and his or her Dependents may elect to continue);
- f. Loss of children's status based on Plan Dependent child eligibility rules (a Dependent child may elect to continue).
- g. You become eligible for Medicare (Spouse and/or Dependent children may elect to continue).

2. Continuation Period. The period for which Coverage may be continued varies depending on the circumstances. In general, Plan Coverage may be continued for:

- a. 18 months for terminated Employees and that Employee's eligible Dependents, or for Employees working reduced hours or who lost Coverage due to change in job class and that Employee's eligible Dependents; and
- b. An additional 11 months for a total of 29 months for qualified COBRA participants (beneficiaries) who receive a disability award from the Federal Social Security Administration. The COBRA beneficiary must be disabled at the time Coverage ended under the District Plan, or within 60 days from the date COBRA continuation began. You or your Dependent must provide a copy of the Social Security disability award stating that the beneficiary was disabled on the date District Coverage ended or within 60 days from the date COBRA continuation began. This notice must be sent by the qualifying COBRA beneficiary within 60 days following the date Social Security approved the disability and within 18 months of the COBRA continuation period. This provision applies to the disabled COBRA beneficiary whether Employee or Dependent.
- c. 36 months for all others eligible for continued benefits (Dependents who lost Dependent eligibility status). If a Dependent loses Dependent status (for example divorce, legal separation or Employee's death, the Employee becomes eligible for Medicare) while Covered under the 18-month continuation period for terminated Employee, that Dependent has Incurred a second event. In such event, the Dependent may be eligible to extend the 18-month period to 36 months.
- d. In no event will COBRA continuation exceed 36 months for any beneficiary.

3. Acquiring Dependent Children. Effective January 1, 1997, qualified beneficiaries include children born, adopted or placed for adoption (and under age 18) during a COBRA continuation period elected by the Employee. The participating Employee can add Coverage for these Dependents if acquired during his or her period of COBRA continuation, and if enrolled within 30 days after the date of birth, adoption or placement for adoption. This change would allow such a child to have his or her own COBRA continuation election rights (if, for example, the parent/employee died). This change applies only if you have health Coverage under COBRA on or after January 1, 1997. If you add a Dependent during a COBRA period, Coverage and participation payments would be adjusted accordingly.

- 4. COBRA Participation Payment.** In order for Coverage to continue, you or your Eligible Dependents will be responsible for the full cost of participation in the Plan, payable in at least monthly Contributions. This cost will be equal to the Employees' Contributions and premium equivalent of Plan Contribution by the Plan sponsor plus 2% of the combined total. This Contribution will increase after 18 months for the additional 11 months of COBRA continuation election due to social security disability. The increased Contribution will equal the Contributions made by you and the Plan Sponsor plus 50 percent of the determined Contribution or premium equivalent.

The first COBRA Contribution must be made within 45 days after the date of the COBRA election by a qualified beneficiary. The payment must cover the period of Coverage from the date of COBRA election retroactive to the date Coverage ended due to the qualifying event. Contributions for subsequent periods of Coverage are due at least monthly based on the date (day of the month) that COBRA continuation became effective. Payment must be made within 30 days following the due date to maintain Coverage. If payment is not made within 30 days following the due date, COBRA Coverage will stop as of the payment due date.

5. COBRA Election Forms

You must notify the District Benefits Office, in writing, of a divorce, legal separation, a child losing eligibility status or other qualifying event within 60 days following the qualifying event. You must notify the District Benefits Office within 60 days of the birth, adoption or placement for adoption of children acquired during COBRA continuation. You must notify the District Benefits Office of a qualifying social security disability award within 60 days of the award and within the first 18 months of COBRA continuation. COBRA continuation of Coverage is administered by POMCO where all inquiries during your COBRA Coverage continuation can be made.

COBRA election forms will be sent to you or your Eligible Dependents, by POMCO, usually within 14 days after notification to the District Benefits Office that a qualifying event has occurred. Payment details for COBRA participation will be sent with the election form. You or your Dependents are required to return the completed form to POMCO selecting the Coverage wanted, (health, individual or family), within 60 days after election forms are received. If a beneficiary fails to return the completed election forms within 60 days, he or she forfeits their rights to COBRA. POMCO has been selected by District to administer its COBRA continuation program where written inquiries can be sent. Phone inquiries concerning COBRA continuation can be made by phoning the POMCO local or toll-free phone number.

- 6. End of COBRA Coverage Continuation.** Once continuation of Coverage is ended, an individual cannot be reinstated for COBRA continuation whether or not the maximum period of COBRA continuation has been met. COBRA continuation of Coverage for you, your Spouse or Dependents will end on the earliest of the following:
- a. The date of the end of the applicable maximum continuation period.
 - b. The date on which the District ceases to provide a health plan to any Employee.
 - c. The due date of the COBRA participation Contribution for failure to make timely payment.
 - d. The date Coverage is acquired under any other group health benefit plan. This does not apply if the acquired plan has a preexisting clause that affects Coverage for the qualifying beneficiary due to an existing condition. COBRA continuation would then end at the time the preexisting clause no longer applies. Refer to ***COBRA Coverage and Preexisting Conditions*** shown below.
 - e. The date a COBRA beneficiary becomes eligible for Medicare.
 - f. The date a qualified COBRA beneficiary is no longer disabled during the 11-month Social Security extension.

7. COBRA Coverage and Preexisting Conditions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, makes it easier for an Employee to change jobs and become Covered by a new employer's health plan even if the Employee or his or her Dependents have a preexisting medical condition. COBRA beneficiaries must notify the District Benefits Office or POMCO when another employer or other group plan covers them.

Effective 7/1/97, HIPAA requires that time, during which you and your Dependents had continuous health Coverage (including COBRA) before changing jobs, will reduce, day by day, any new plan's pre-existing conditions exclusions. Generally, this law applies to each Plan based on the beginning of its Plan year, on or after July 1997. In this situation, COBRA Coverage ends for a beneficiary when that beneficiary becomes Covered under the new Employer's group health plan and preexisting limitations do not apply to that beneficiary. **In general, if a beneficiary had health coverage for the previous 12 months, he or she will be covered by a new employer's plan without regard to any pre-existing conditions.** Contact your new Employer to verify their coverage and any applicable pre-existing exclusion. If you or your Dependents become eligible under a new plan, you or your Dependents should contact POMCO to provide a coverage certification showing the duration of Coverage under this Plan. When your COBRA Coverage ends, POMCO will automatically issue coverage certifications. New employers may request coverage certifications when you enroll in their health plans.

Please Note

Any individual who elects to continue Coverage under COBRA will be eligible for the same Coverage in effect at the time that person first lost Plan eligibility status. Subsequent Plan Amendments apply to COBRA continuation in the same manner for individuals who are qualified participants under the Plan. Benefits will not be payable for Covered Expenses Incurred during a period of COBRA continuation until the applicable Contribution payment has been made for that period of continuation.

*This continuation Coverage could be considered a secondary plan under the Coordination of Benefits provision shown later in this SPD. COBRA participants are considered persons without employment status. Medicare could be primary payer according to Medicare Secondary Rules. If eligible and not already enrolled in Medicare, persons without employment status should do so immediately. Refer to **Section V - Medicare Integration with Plan Benefits**. If a person becomes eligible for Medicare after COBRA continuation takes effect, Coverage under this Plan will end on the effective date of Medicare eligibility.*

I. PLAN CANCELLATION

If the Plan cancels, Coverage will end for all persons enrolled in the Plan.

SECTION III – BENEFIT MANAGEMENT PROGRAM

This Program could be canceled, revised, or changed at the discretion of the Plan Administrator based on government regulations or on current trends and standards for medical care. You will be notified if changes are made.

The Benefit Management Program applies to all Enrollees whose primary Coverage is this Plan. It does not apply if your primary coverage is Medicare according to Medicare secondary payer rules or another group health benefit plan according to the coordination of benefits rules for order of benefit determination. The Benefit Management Program is designed to answer questions and explore your choices when you or your Dependents face Hospitalization, Surgery or extensive medical care. The Benefit Management Program consists of Pre-admission Review, Concurrent Inpatient Review, Medical Case Management/Discharge Planning and Medical Procedure Review. This Benefit Management Program is administered by:

POMCO Benefit Management Unit
P.O. Box 6329
Syracuse, NY 13217-6329
Phone Local: (315) 432-5567 or Toll-free: 1-800-358-8399

This is a 24-hour service. If you wish to talk to the POMCO nurses, you must call between 8:30 A.M. and 4:30 P.M. on normal business days. Otherwise, provide complete information as requested by voice mail message.

Whenever you call the POMCO Benefit Management nurses, be prepared to supply the following information:

- **Enrollee's Social Security Number (Number shown on the Plan identification card)**
- **The patient's name and address**
- **Physician's name, address and phone number**
- **Name of Hospital and the anticipated date of admission or date admitted.**

A. PRE-ADMISSION REVIEW

According to the Newborns' & Mothers' Health Protection Act, a federal law, a health plan or its managed care program, that offers coverage for Hospital stays in connection with childbirth cannot limit that coverage to less than a 48-hour Hospital stay following an uncomplicated normal delivery; or less than a 96-hour Hospital stay following a cesarean section delivery. In addition, the health Plan cannot restrict benefits for any portion of the required minimum stays in a manner that is less favorable than the benefits provided for any preceding portion of the stay. Additionally, this Plan will abide by a state law that provides more favorable maternity stays when such laws affect this Plan.

The Pre-admission review is a preliminary evaluation by the POMCO managed care staff to decide whether an Inpatient setting is Medically Necessary according to Plan provisions. If the Medical Necessity of the Inpatient setting is established based on available information, the admission will be pre-certified. If the Medical Necessity is not established based on available information, the Inpatient admission will not be pre-certified. Written notification of the POMCO Managed Care Unit decision will be mailed to you, your Doctor and the facility within 48 hours (two business days) after their review.

Pre-admission certification does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review of the Inpatient setting based entirely on the limited information provided to the Managed Care nurse at the time of the pre-admission review. If medical documentation at the time services are rendered is other than provided during this initial review, and it is decided according to Plan provisions and limitations that the Hospitalization was not Medically Necessary or otherwise excluded under the Plan, benefits may be denied.

1. Mandatory Enrollee Telephone Requirement. Others may initiate the required phone call, such as Family Members, Physicians, or Hospital personnel. However, it is your responsibility to confirm that the call was made. This review applies to any Hospital or other Covered facility in the USA, including Hawaii and Alaska. The purpose of the Enrollee or Covered Person telephone call is to initiate the pre-admission review and to advise the patient whether Coverage is available. If this Plan is primary, you must call POMCO before a scheduled admission or after an emergency admission to any Inpatient facility or before Home Health Care Agency services are rendered. You must call as follows:

- a. At least seven (7) days before an admission or when the Physician decides that you or one of your Dependents requires admission to a Hospital, Skilled Nursing Facility, Psychiatric Facility, or any other Inpatient facility;
- b. Within 48 hours after an emergency or urgent admission; or
- c. Within 24 hours following continued maternity Inpatient stays after 48 hours after normal delivery or 96 hours after cesarean section. For all other maternity admissions, follow instructions shown in “a.” or “b.” above;
- d. Within 24 hours following continued Inpatient stays after 96 hours for newborns;
- e. Before home care begins when the Physician decides that you or your Dependent requires home health care.

2. Noncompliance Benefit Reduction

Informing the Hospital, facility or your Doctor of the pre-admission review requirement does not eliminate this benefit reduction if the phone call is not made. If you fail to make the pre-admission phone call, and it is decided at the time of claim submission, that the Inpatient admission was not Medically Necessary, benefits could be denied.

If you fail to comply with the phone call requirements of this review, you will be subject to a **\$250.00 reduction** of available benefits for Hospital or other Inpatient facility Covered Services.

B. CONCURRENT REVIEW

If you or your Eligible Dependents are confined in a Hospital or other approved facility, the POMCO Managed Care Unit staff will monitor the patient's progress, severity of Illness, and intensity of services via the concurrent review procedures. If it is determined, based on this review, that in-patient care is no longer Medically Necessary, you, the attending Doctor and the in-patient facility will be notified no later than the day before the day on which in-patient benefits cease.

C. MEDICAL CASE MANAGEMENT/DISCHARGE PLANNING

If you or your Eligible Dependents require extended care or home care, the POMCO Managed Care staff will help you make decisions concerning treatment plans and facilities to coordinate medical services and Plan benefits. This can be initiated by you or by the POMCO Managed Care staff. Participation is voluntary and can be ended any time. Coordination of services could include alternate treatment or an alternate facility. The Managed Care

Unit staff will work with you and your Doctor to use services Covered by the Plan.

D. MEDICAL PROCEDURE REVIEW

- 1. Mandatory Enrollee Telephone Requirement.** It is your responsibility to make the required phone call(s) or to confirm other persons such as Family Member, Physician or Hospital personnel makes the call. If this Health Plan is primary, you are required to call POMCO whenever you or your Dependents are scheduled as an Inpatient or Outpatient (Hospital, office or other Outpatient facility) for the following procedures:

Dilatation and Curettage (Unrelated to Pregnancy)
Gastric Stapling
Hernia Repair (Laparoscopic)
MRI or MRA (Magnetic Resonance Imaging or Angiography)
Varicose Vein Surgery

The purpose of this phone call is to initiate an evaluation to decide if a second opinion is required. Your phone call will start the medical review process. POMCO will advise you whether a second opinion is needed within two business days after their evaluation.

- 2. Mandatory Second Opinion Consultation (SOC).** You or your Dependents may be required to obtain a Second Opinion Consultation (SOC) from a Physician whose specialty is similar to the attending Physician. If you or your Dependents are required to obtain a SOC, you may seek this consultation from a POMCO Network Provider and benefits will be reimbursed in full with no Copayment. If you seek this consultation from a Nonparticipating Provider, the benefit will be reimbursed in full up to the Usual, Customary and Reasonable Charge for this service. The SOC must be secured from a board-certified specialist in the appropriate field of medicine for which the patient is contemplating Surgery and must not be a part of the same medical or surgical group as the first opinion Physician.

After the SOC, it is up to you or your Eligible Dependent whether to proceed with the procedure. If you decide to go ahead, usual Plan limitations and exclusions apply to the procedure expenses. However, if the SOC specialist does the procedure, Plan benefits will not be paid for the SOC.

Once you meet the requirements of this review, the procedure(s) must be done within six months. If the procedure(s) is not done within six months or if the Doctor chooses an alternate procedure(s) and then decides later to do the initial proposed procedure(s), you must make another phone call to initiate the review procedures.

- 3. SOC Noncompliance Benefit Reduction.** If you do not comply with the requirements of this review and you or your Dependent receives one or more of the listed procedures, you will be responsible for the payment of the following:
 - In addition to any applicable Copayments, 50% of the scheduled allowance or \$250.00, *whichever is less*, for services by a **Network Provider**; or
 - In addition to the major medical Copayment and Deductible amounts, if applicable, 50% of the Allowable Fees or \$250.00, *whichever is less*, for services by an **Out-of-Network Provider**; and
 - If the patient is admitted to the Hospital as an Inpatient for a procedure that required a SOC and for which one was not obtained, you will be liable for a **benefit reduction of \$250.00** of the available Hospital benefit or other approved Inpatient facility benefits.

E. VOLUNTARY SECOND OPINION CONSULTATION

If you or your Eligible Dependent is scheduled for a surgical procedure not listed under Medical Procedure Review, you may want a second opinion before you decide to proceed with the procedure. If this Plan is primary when you or your Eligible Dependent are scheduled for a surgical procedure not listed under Medical Procedure Review, you may call the POMCO Managed Care Unit to request a Voluntary Second Opinion Consultation. It is advisable to allow two (2) weeks for scheduling the Second Opinion Consultation.

If you use a Network Provider from the POMCO Provider Network for the Second Opinion Consultation, full payment will be made to the Provider for that opinion. If you do not use a Network Provider for a Second Opinion Consultation, full reimbursement for that opinion will be made based on the Usual, Customary and Reasonable Charges. If Second Opinion Consultation is not obtained through this program, usual Plan benefits will apply (typically 80%).

F. DURABLE MEDICAL EQUIPMENT REVIEW

When this Plan is primary, you are required to call the POMCO Benefits Management Unit when you or your Dependent requires the rental or purchase of Durable Medical Equipment (DME) **and** the cost of the DME is expected to exceed \$100.00. Others may initiate the required phone call, such as Family Members, doctors or Hospital personnel. However, it is your responsibility to confirm that the call was made. Failure to make the phone call may result in denial of benefits.

The purpose of the phone call is to obtain a preliminary verification that the DME meets the Plan provisions and limitations. The POMCO Benefit Management staff will also direct you to DME Providers that can save costs for you and the Plan. You may choose to utilize the recommended DME Provider or any other DME Provider for the rental or purchase of the approved DME. Benefits will be based on whether you choose a Network or Out-of-Network Provider.

DME verification does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review of the DME based entirely on the limited information provided to the Managed Care nurse at the time of the DME review. If medical documentation at the time services are rendered is other than provided during the initial review, and it is found according to Plan provisions and limitations that the DME was not Medically Necessary or otherwise excluded under the Plan, benefits could be denied.

Please Note

*All claims are subject to a review to decide if services are Covered according to Plan limitations and exclusions. A second opinion consultation does not guarantee benefits. You must comply with requests for additional medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. **Treatment decisions are independent from payment decisions.** The patient's Physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in or excluded from Coverage under the Plan.*

SECTION IV - COVERED SERVICES

The Plan pays benefits for a broad range of medical services considered Medically Necessary, according to Plan provisions and limitations, for the treatment of an Illness or Injury. Such services must be rendered by a Covered Provider and recommended or ordered by the attending Physician. Unless specifically included, care unrelated to treatment of an Illness or Injury, or care that is considered routine or preventive is not Covered.

The following pages provide details of Your Coverage. Covered Services are subject to Plan limitations and exclusions. Refer to **Section I - Summary of Benefits** for information on benefit limits. Also, refer to **Section X - Definitions** that gives further explanations of terms that apply to Plan Coverage. Charges that are more than Allowable Fees are not Covered. All benefits are based on Allowable Fees for Covered Services or Supplies. Allowable Fees for Network Providers are the negotiated or scheduled network allowances for Covered procedures. For Out of Network Providers, Allowable Fees are the usual, customary and reasonable charges for Covered Services. See **Section I - Summary of Benefits** for information on benefit limits, **Section VII - Plan Exclusions** for details on expenses not Covered, and **Section X - Definitions** for more information concerning terms that may apply to the Plan.

Federal Mastectomy Provision Notice. On October 21, 1998, Public Health Service Act was amended to add a new section that requires group health plans providing medical and surgical benefits with respect to a Covered mastectomy to provide the following Coverage to an eligible plan participant who elects breast reconstruction in connection with the mastectomy:

- a) Reconstruction of the breast on which the mastectomy has been performed.
- b) Surgery or reconstruction of the other breast to produce symmetrical appearance; and
- c) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema;
- d) Coverage to be provided in a manner determined in consultation with the attending Physician and the patient.

A. PARTICIPATING PROVIDER NETWORK PROGRAM (NETWORK)

The Participating Provider Program is offered through the POMCO/MultiPlan Allied Network of Participating Providers. The POMCO/MultiPlan Allied Network is a nationwide network of Participating Providers and Hospitals consisting of more than 108,000 Providers and 40,000 Hospitals and ancillary facilities. You or your Dependents are free to choose either a Network or Out of Network Provider. However, as Network Provider fees are generally lower than Out of Network Provider fees, you save costs for you and the Plan. A directory of Participating Providers is available for your review at the District Benefits Office or you may call for information on Network Providers near you. You may also access the POMCO/MultiPlan Allied Network directory on the POMCO website: www.pomcoplus.com.

Participating Providers have a written agreement to accept a scheduled or negotiated (Network) allowance as their charge for most Covered Services or Supplies. Available Plan benefits are paid directly to the Participating Provider (Network Provider). The Network Provider submits claims directly to POMCO. Each Network Provider maintains their personal professional liability insurance Coverage. Neither POMCO nor the POMCO/MultiPlan Allied Network give advice concerning medical care. They are administrative bodies only.

Usually, the Network Provider Allowable Fees (network allowance) will be considered as payment in full for Covered Services. If you or your Dependents choose a Network Provider for healthcare, you need only pay a nominal Copayment amount, if applicable. Benefit limits and Copayment amounts are shown in **Section I - Summary of Benefits**. If you choose an Out of Network Provider, you will be responsible for charges that are more than the Usual, Customary and Reasonable Charges plus any applicable medical expense Deductible and Percentage Copayment balance.

Covered Services for Network Providers are the same as those shown in this section under Preventive Care, Hospital Expense, Medical/Surgical Expense and Major Medical Expense Benefits. Some services and supplies shown in this section are Covered only when such services are rendered and billed by Network Providers. This will be noted whenever Network only Coverage applies. Plan limitations and exclusions apply, unless shown otherwise.

Please Note

*The Benefit Management Program and other Plan review requirements apply to services rendered by a Network Provider, the same as to a Nonparticipating Provider. **Use of a Network Provider is not a guarantee of benefits. Benefits will be allowed only to the extent that services or supplies are Covered under the terms and provisions of the Plan.***

LabOne Network Benefit. An optional Lab Card benefit is included under this program. The Plan will allow Full Benefits when you or your Dependents present your Plan identification Card at the Physician's office and request that LabOne be used for diagnostic lab work. LabOne is a fully accredited and certified laboratory that has an agreement with the Plan Administrator to provide quality laboratory testing at significant savings. You are encouraged to use this benefit to save costs for yourself and the Plan. If you need testing on an emergency basis or if you choose not to use your Plan identification card, your regular health benefits will apply. If other laboratories are used for the lab tests, your expenses will be subject to applicable Copayments and Deductibles.

Please Note

Your Physician will usually collect cultures, pap smears, blood et al. However, if your Physician is unable to collect all your specimens, please call LabOne at 1-800-646-7788 to see if you can use the Lab Card benefit by going to an approved collection center. If you have any questions concerning the Lab Card program, you may call LabOne Clinical Client Services at the above phone number or call the District Benefits Office or POMCO for information.

B. PREVENTIVE CARE EXPENSE BENEFITS (WELLNESS OR ROUTINE CARE)

Coverage is available for limited routine screening exams for preventive care. Preventive care is wellness or routine care unrelated to the diagnosis or treatment of specific symptoms or specific Illness or Injury. Coverage is available under Medical Expense Benefits for diagnostic testing and exams related to specific symptoms or treatment of an Illness or Injury. If care or management of an Illness or Injury requiring minimal time or minimal professional expertise is done during a visit that is primarily for preventive care, the visit will be considered as preventive care, subject to Plan limitations. Only the following routine services are Covered for preventive or wellness care. Refer to **Section I - Summary of Benefits** under *Preventive Care Benefits* for benefit limits.

- 1. Well Child Care.** Benefits are available for routine well child care rendered for enrolled and eligible Dependent children from birth to age 18 (until but not including 18th birthday). Routine well child care rendered in a Physician's office, Hospital or clinics licensed to render such care, includes the following services only:

- a. **Newborn Nursery Care.** Benefits are available for initial routine newborn exam or nursery care rendered and billed by Physicians while newborn is confined in the Hospital nursery. Routine newborn nursery care is limited to four days of Inpatient Care. Payment will not be made for routine care after four days. For example, extra nursery days due to the mother's extended Hospital stay will not be Covered. However, if child is ill, usual Plan benefits will apply. Plan includes Coverage for routine circumcisions. Routine newborn care billed by an anesthesiologist or the delivering Physician is not Covered.

Please Note

*Your biological child is eligible for 30 days from the moment of birth under your individual or family Coverage. However, after 30 days, Coverage will not be available unless the child is enrolled as a Dependent in your family Coverage. **Other eligible newborns must be enrolled in your family Coverage to be eligible from the moment of birth.***

- b. **Well Child Care/Immunizations.** When a Network Provider is used, you will be responsible for payment of the Network Copayment. However, if an out of Network Provider is used, benefits will be determined as if a Network Provider was used. The Plan will base benefits on the Network allowance, rather than the UCR allowance for Covered Services. You will be responsible for the Network Copayments plus charges more than the Network allowance. **Section I - Summary of Benefits** under **Preventive Care Expense Benefits.** Coverage is limited to the following services when rendered for Dependent children up to age 18:
- 1) Usual well child laboratory screening and testing.
 - 2) Usual routine well child physical exams.
 - 3) Developmental assessments.
 - 4) Age appropriate immunizations for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis b, rotavirus, haemophilus influenza type b, varicella (chicken pox) based on immunization guidelines recommended by the American Academy of Pediatrics and/or as designated by New York State Superintendent of Insurance. Immunizations given later than the recommended age level will still be Covered if appropriate and administered to the child before age 18. Immunizations for other diseases may be Covered when recommended by the American Academy of Pediatrics or when required by New York State Law or designated by the New York State Superintendent of Insurance.
 - 5) Well child care Coverage is available for usual visit frequency as follows:
 - a) At birth for newborn routine nursery care
 - b) Every two months from birth to six months.
 - c) Every three months from nine to 18 months.
 - d) Every year from ages two to six years.
 - e) Every two years for ages seven to 18 years.
2. **Adult Routine or Well Care (Active Employees and their Dependents Only).** Benefits are available for routine preventive physical examinations and related tests (including routine hearing tests) for active Employees, their Spouse, and Eligible Dependents, age 18 or older. Coverage is limited to one complete exam and related tests every two years for each Covered Person. This Coverage is not available for retirees and their Dependents. See **Section I - Summary of Plan Benefits** for benefit limits.
3. **Cervical Cytology/Pap Test and Exam (Network Only).** Coverage only provided when rendered and billed by Network Providers. Benefits are available for annual cervical cytology cancer screening services including related cervical exam, collecting and preparing pap smears, and the laboratory diagnostic service to examine and evaluate the pap smear. Coverage is limited to cervical cancer screening for enrolled eligible females 18

years of age or older and to once in twelve consecutive months.

4. **Mammography Screening.** Benefits are available for Allowable Fees billed by a Hospital, clinic, or Doctor for routine mammography screening under the following conditions:
 - a. A mammography with a Doctor's orders for Covered Persons, at any age, with a personal medical history of breast cancer, or whose mother or sister has a history of breast cancer;
 - b. A single baseline mammography for Covered Persons who are 35-39 years of age;
 - c. A mammography every two years for Covered Persons who are 40-49 years of age, or more frequently upon recommendation of a Doctor with medical rationale;
 - d. An annual mammography for Covered Persons who are 50 years of age or older.
5. **Prostate Cancer Screening Program.** The District offers a special program for routine prostate cancer screening exams and related tests. *The District will schedule this program once a year.* You will receive an annual announcement showing the scheduled dates, parameters of the program, and a list of the participating healthcare Providers that have been engaged to render the program services.

C. HOSPITAL EXPENSE BENEFITS

1. General Hospital

Phone calls are required by you before most elective or scheduled Inpatient admissions or within 48 hours after an urgent or emergency admission. Refer to **Section III - Benefit Management Program** for instructions.

Benefits are available for Allowable Fees billed by an General Hospital for Outpatient and acute care Inpatient services. Covered Services must be actually rendered and must be recommended by the attending Physician for any care needed by you or your Eligible Dependent. Such care must be Medically Necessary according to the provisions of the Plan. Services and supplies must be provided by the Hospital and rendered by Employees of the Hospital. The person receiving services or supplies must be admitted to the Hospital for Inpatient Care or be present for Outpatient care. After Hospital Expense Benefits are exhausted, additional Coverage is available under *Major Medical Expense Benefits* shown later in this section. Charges for Physician services and private duty nurses are Covered separately under *Major Medical Expense Benefits*.

a. Inpatient Services

- 1) **Room and Board** including general nursing in semi-private rooms (two or more beds), intensive care units, critical care units, cardiac care units or similar units. If confined in a private room, the Plan allows the Average Semi-Private Room Rate. You will be responsible for payment of charges more than the Average Semi-Private Room Rate. Room and board charges billed for the date of discharge are not Covered.
- 2) **Hospital Miscellaneous** medical supplies or medical services received during an Inpatient period in which room and board charges are Covered. Take home supplies or drugs are not Covered under this benefit. Personal services such as telephone, TV, barber, etc. are not considered medical expenses.
- 3) **Medical/Surgical Benefit Limit** is 365 days per Spell of Illness for room and board and ancillary charges or per Spell of Accidental Injury for Injuries sustained from the same accident.. See below

for separate limits for Psychiatric Care. Refer to **Section X-Definitions** under *Spell of Illness* and *Spell of Accidental Injury* for explanation.

- 4) **Psychiatric Care Limit is 120 days per Calendar Year.** Days count toward the Medical/Surgical limit of 365 days per Spell of Illness. Psychiatric Care is only allowed when the patient requires such care for the protection of himself or others or where the course of treatment can only be carried out on an Inpatient basis. Coverage includes public mental health Hospitals. Coverage includes General Hospitals and public mental health Hospitals. However, private psychiatric facilities are Covered separately under *Major Medical Expense Benefits* shown later in this section.
- 5) **Pregnancy or Maternity** care is allowed the same as any other Illness.
- 6) **Newborn Nursery Care.** The biological newborn of an Employee is eligible for the first 30 days following the moment of birth under the Employee's individual or family Coverage. Separate enrollment need not be made. However, Coverage will not be available after the first 30 days unless the newborn is enrolled under the Employee's family Coverage. Other eligible newborns such as pre-adoptive newborns are Covered from the moment of birth only when enrolled within 30 days after the date of birth. Coverage is available for sick and routine care, including Hospital services and supplies for routine circumcision. Routine care is limited to four days. Coverage beyond four days will be excluded unless required due to care of baby's Illness or Injury or if special care needed for prematurity. If routine nursery care is extended primarily due to the mother's continued stay, benefits will not be available for the additional days even if the mother provides personal newborn care, such as breastfeeding.

Please Note

According to the Newborns' & Mothers' Health Protection Act, a Federal law, a health plan, or its benefit management program, that offers Coverage for Hospital stays in connection with childbirth cannot limit that coverage to less than a 48-hour Hospital stay following an uncomplicated normal delivery; or less than a 96-hour Hospital stay following a cesarean section delivery. In addition, the health Plan cannot restrict benefits for any portion of the required minimum stays in a manner that is less favorable than the benefits provided for any preceding portion of the stay. Additionally, this Plan will abide by a state law that provides more favorable maternity stays when such laws affect this Plan.

- b. **Outpatient Services.** Benefits are available for certain Outpatient services billed by the Hospital. Refer to *Preventive Care Expense Benefits* shown previously in this section for additional limited Coverage. Copayments could apply, refer to **Section I - Summary of Plan Benefits** for details. Coverage under this benefit is limited to services and supplies rendered for the following Outpatient care:
 - 1) **Emergency Care** or initial treatment within 72 hours of an Accidental Injury that requires this type of care or within 12 hours of the first acute symptoms of a sudden and serious Illness. The sudden and serious Illness must be such that failure to provide emergency care could reasonably be expected to result in serious impairment of body function or jeopardize the patient's life. Coverage includes use of emergency room and related services and supplies for the Covered emergency care.
 - 2) **Surgery** services and supplies by the Hospital are Covered. This includes services related to setting of a fracture or dislocation. However, follow up services such as suture removal, cast removal, recheck exams etc., are not Covered under this benefit. Coverage includes use of emergency or Outpatient room and related services and supplies on the same day as the Surgery. Coverage for follow-up care is available under *Major Medical Expenses* shown later in this section.
 - 3) **Radiation Therapy** services and supplies by the Hospital are Covered. Separate charges for the use

of the Hospital emergency or Outpatient rooms are not Covered when used for radiation therapy.

- 4) **Diagnostic Testing** (X-rays, Laboratory, and other Diagnostic Tests) are Covered when ordered by the Physician for diagnosis of specific symptoms or when related to treatment of an Illness or Injury. Patient must be present to receive services. *If patient not present*, services are Covered under **Major Medical Expense Benefits** shown later in this section. Separate charges for the use of the Hospital emergency or Outpatient rooms are not Covered when used for diagnostic testing. Routine or preventive diagnostic services are not Covered under this benefit. See **Preventive Care Expense Benefits** for limited Coverage.
- 5) **Pre-admission Testing** is Covered when all of the following requirements are met:
- a) The tests are ordered by a Physician as a preliminary requirement for you or your Dependent's admission as a registered bed patient for Surgery in the same Hospital;
 - b) Tests must be consistent with the diagnosis and treatment of the condition for which Surgery is needed;
 - c) The reservation for a Hospital bed and operating room was made before testing was done;
 - d) The patient must be physically present at the Hospital for needed tests;
 - e) Surgery must take place within 14 days after the tests are rendered.

Separate charges for the use of the Hospital emergency or Outpatient rooms are not Covered when used for pre-admission testing.

- 6) **Kidney Dialysis** treatment for chronic kidney disease is Covered for services rendered in the Outpatient department of the Hospital or in a Medicare certified Outpatient dialysis facility. Separate charges for the use of the Hospital emergency or Outpatient rooms are not Covered when used for kidney dialysis.

Please Note

*A person receiving kidney dialysis could be eligible for Medicare due to End Stage Renal Disease (ESRD). Refer to **Section V-Medicare Integration with Plan Benefits**.*

- 7) **Physical Therapy** is Covered only when **all** of the following conditions are met:
- a) Physical Therapy is ordered by the attending Physician to improve body function. (Plan excludes Maintenance Care). Coverage ends when maximum improvement has been met or when therapy no longer results in significant or measurable improvement of function).
 - b) Therapy is related to a condition for which the patient had Surgery or was previously Hospitalized; and
 - c) Therapy must begin no later than six months from the date of Surgery or the date of Hospital discharge and must be rendered within 365 days following the date of Surgery or Hospital discharge.

Separate charges for the use of the Hospital emergency or Outpatient rooms are not Covered under this benefit.

- 8) **Other Hospital Outpatient** services are considered under **Major Medical Expense Benefits** shown later in this section.

2. **Birth Center Facility.** Benefits are available for services and supplies for maternity or Pregnancy care rendered by an approved licensed Birth Center facility to the extent such expenses would have been allowed if provided by a Hospital. Coverage includes routine nursery care.

3. **Skilled Nursing Facility/Rehabilitation Facility (SNF) Inpatient Care**

Phone calls are required by you before most elective or scheduled Inpatient admissions or within 48 hours after an urgent or emergency admission. Refer to **Section III - Benefit Management Program** for instructions. Outpatient SNF services are Covered under *Major Medical Expense Benefits* shown later in this section. **Note:** If you or your Dependents are eligible for Medicare Primary Coverage, according to Medicare Secondary Payer rules, Inpatient SNF care is not Covered. This applies whether or not the eligible person is enrolled in Medicare. This Plan will not reimburse Medicare deductibles and coinsurance. This exclusion applies even if Medicare SNF Coverage is exhausted.

Benefit days are limited to 150 Inpatient days per Spell of Illness or per Spell of Accidental Injury for Injuries from the same accident. Days count toward the Hospital 365 days per Spell of Illness or per Spell of Accidental Injury limits. Additional Coverage for Inpatient SNF expenses *is not* available under *Major Medical Expense Benefits*.

a. **Coverage Criteria.** To be eligible for SNF Inpatient benefits care must meet all of the following:

- 1) Care must be Medically Necessary and at a skilled level of care according to Plan provisions. Skilled care is care of an acute nature that must be furnished by skilled personnel (qualified technical or professional health personnel) on a daily basis. In no event are benefits available for Custodial Care, Maintenance Care, nursing home, residential, long-term care or any care that cannot reasonably be expected to lessen the patient's disability enabling him or her to leave an institution.
- 2) Coverage will only be provided for as long as Inpatient Care in an General Hospital would have been necessary if care in a Skilled Nursing Facility were not provided; and
- 3) Diagnostic and therapeutic services must be provided and billed by the facility and rendered by employees of the facility.

b. **Covered SNF Services**

- 1) Room and board charges up to the semi-private rate. Private room charges more than the Average Semi-private Room Rate are excluded. Room and board charges billed on the date of discharge are not Covered;
- 2) Rehabilitative physical, occupational or speech therapy;
- 3) Medical social services; and
- 4) Ancillary or Miscellaneous medical services or supplies, appliances and equipment furnished for use in the facility that are ordinarily provided by the facility for its patients and would be Covered if it was rendered during an Inpatient stay at a Hospital.

4. **Home Health Care Agency**

All Home Health Care Agency services require a phone call as part of the Benefit Management Program. Refer to **Section III – Benefit Management Program** for details.

Benefits are available for an Approved Home Health Care Plan when home care services are rendered and

billed by an accredited and certified Home Health Care Agency. To be eligible for this benefit, the patient's condition must be such that confinement in a Hospital or Skilled Nursing Facility would be necessary if home health care services were not provided. Care must be pre-approved for Coverage through the Benefit Management Program and based on written recommendation by the attending Physician.

Each visit by a member of the home care team is considered one visit. Four hours of care by a Home Health Aide is considered one visit. Three visits equal one benefit day. Benefit days are limited to 365 days per Spell of Illness or per Spell of Accidental Injury and count toward the General Hospital Inpatient 365-day limits. Benefits are available for an Approved Home Health Care Plan when home care services are rendered and billed by an accredited and certified Home Health Care Agency. After this benefit is exhausted, additional Coverage *is not* available under **Major Medical Expense Benefits**. The following services are Covered under this benefit:

- a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN). Full-time care is not Covered;
- b. Part-time or intermittent Home Health Aide services rendered primarily for the care of the patient. Full time care is not Covered;
- c. Rehabilitative physical, occupational and speech therapy;
- d. Medical Supplies, drugs and medicines that would have been allowed if the patient were confined;
- e. Laboratory services that would have been Covered if rendered during an Inpatient stay in a Hospital or Skilled Nursing Facility; and
- f. If your Doctor or the Home Health Care Agency considers it Medically Necessary,
 - 1) Radiology and EKG services; social services by medical social worker;
 - 2) Ambulance or ambulette transportation services between you home and the Hospital, if it is necessary for your care.

5. Hospice Agency

If you or your Dependent start hospice care and choose to cancel the Hospice Agency services, usual Plan benefits will become available. However, you must notify the Claims Administrator in writing that Hospice Agency services have been voluntarily stopped.

Benefits are available for the period during which the Hospice Agency accepts the patient in its program. The patient must be diagnosed as terminal with six months or less to live. *During this period of acceptance, all the patients' medical services must be provided by or obtained through the Hospice Agency. The Hospice Agency must bill all Covered Services or Supplies.* Benefits are available for the following hospice services and supplies when rendered as part of the Hospice Care Plan:

- a. Bed patient either in a designated Hospice Unit or in a regular Hospital bed;
- b. Day care service provided by the Hospice Agency;
- c. Home care and Outpatient services provided by the Hospice Agency including intermittent nursing by a registered nurse or licensed practical nurse or by a Home Health Aide;
- d. Physical, occupational, speech, and respiratory therapy;
- e. Medical social services and nutritional services;
- f. Laboratory, x-rays, chemotherapy and radiation therapy when needed to control symptoms;
- g. Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not available if the drugs or medications are of an Experimental nature;
- h. Medical care provided by the Hospice Agency Physician or other Physician designated to render services by the Hospice Agency; and
- i. Bereavement counseling for Family Members any time during hospice care or within one year after patient's death.

6. Alcohol Abuse Facility

Substance (drugs other than alcohol) abuse expenses are considered under *Major Medical Expense Benefits* shown later in this section.

- a. **Inpatient Care.** Benefits are available for Inpatient services rendered and billed by a certified Alcohol Abuse Facility (free-standing Inpatient facility or Hospital Inpatient center) for rehabilitation treatment of alcohol abuse. The Plan of Care must be approved for Coverage through the Benefit Management Program. The Provider must send a written treatment plan no later than 10 days after Inpatient Care begins. If the treatment plan is not sent within 10 days, benefits will not be paid. If Inpatient Care is not approved for Coverage or is not found Medically Necessary according to Plan provisions, benefits will not be paid. Refer to **Section I - Summary of Benefits** for benefit limits. Private room charges are limited to the Average Semi-Private Room Rate, whatever the reason for its use. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training. After benefits exhausted, additional Coverage *is not* available under Major Medical Expense Benefits.
- b. **Outpatient Care.** Benefits are available for an Approved Plan of Care for Outpatient services rendered in a certified Alcohol Abuse Facility (freestanding agency or facility or a Hospital center) for the diagnosis and treatment of alcoholism or drug addiction. To be considered for benefits, the Claims Administrator must approve the Plan of Care for Plan Coverage. The Provider should send a written treatment plan before care begins or within 10 days after care begins. If treatment plan not received within 10 days, benefits will not be paid.

Each visit must consist of at least one of the following: individual or group counseling; activity rehabilitation therapy; or diagnostic evaluations by a Doctor or other licensed professional to decide the nature and extent of the patient's Illness. Coverage includes limited benefits for Family Member counseling. Benefits are not payable for visits that consist primarily of participation in programs of a social, recreational, or companionship nature. Services must be rendered by the employees of the facility for services provided by the facility. Refer to **Section I - Summary of Benefits** for benefit limits. After benefits exhausted, additional Coverage *is not* available under Major Medical Expense Benefits.

- 7. Kidney Dialysis.** Benefits are available for kidney dialysis rendered in a Physicians office, clinic, Medicare approved freestanding kidney dialysis center or at home. Coverage includes services and supplies related to the dialysis procedure. Professional services are Covered separately under Major Medical Expense Benefits. If you are on *home dialysis*, Coverage includes related laboratory tests and consumable and expendable supplies. Equipment found Medically Necessary by the Claims Administrator will also be Covered. Benefits are not available for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, air conditioners or for convenience or comfort items.

Please note

*A person receiving kidney dialysis could be eligible for Medicare due to End Stage Renal Disease (ESRD). Refer to **Section V - Medicare Integration with Plan Benefits.***

D. MAJOR MEDICAL EXPENSE BENEFITS

This Coverage becomes available after Hospital Expense Benefits are exhausted. Major Medical Expense Benefits will not duplicate any charges Covered by or paid by *Hospital Expense Benefits* shown previously in this section.

Major Medical Expense Benefits are available for Allowable Fees Incurred for a wide range of medical services and supplies. Covered Services or Supplies must be actually rendered for you or your Eligible Dependents and must be recommended by the attending Physician. Services and supplies must be found Medically Necessary for the treatment of Illness or Injury according to Plan provisions, unless specifically shown otherwise in the Plan. Unless shown otherwise, Allowable Fees for Covered Services are subject to the Calendar Year Deductible, Copayment limit and Lifetime benefit maximums. Refer to **Section I-Summary of Benefits** under Major Medical Expense Benefits for details.

Please Note

Phone calls are required before elective or scheduled Inpatient admissions or within 48 hours of an urgent or emergency admission. Some surgical or medical procedures require a phone call before services rendered. Failure to make mandatory phone calls could result in reduction of benefits. Refer to Section III - Benefit Management Program for details and instructions.

1. General Hospital

- a. Inpatient Services.** After Hospital Expense Benefits are exhausted, this benefit becomes available for acute care Inpatient expenses. Coverage includes room and board and ancillary charges on the same basis as shown under Hospital Expense Benefits. If a private room is used, Coverage is limited to Average Semi-Private Room Rate. You will be responsible for charges more than the average semi-private room rate. Room and Board charges for the date of discharge are not Covered. The Plan excludes Inpatient private duty nursing. Physician expenses are Covered separately.
- b. Outpatient Services.** After Hospital Expense Benefits are exhausted, this benefit becomes available for Medically Necessary services and supplies provided for Hospital Outpatient services. To be eligible for Coverage under this benefit, medical services and supplies must otherwise be Covered under the Plan, subject to the same limitations. Physician charges are Covered separately.

2. Skilled Nursing Facility (SNF)/Outpatient

Inpatient services are Covered under *Hospital Expense Benefits* shown previously in this section.

Coverage includes Allowable Fees for Outpatient SNF services and supplies used during Covered treatment of Illness or Injury. *To be eligible*, medical services and supplies must otherwise be Covered under the Plan, subject to the same limitations.

7. Private Psychiatric Facility

Phone calls are required. Refer to **Section III - Benefit Management Program** for details.

Benefits are available for Allowable Fees billed by an accredited Private Psychiatric Facility for Inpatient Psychiatric Care. The patient's condition must be so intense that he or she is a danger to self or others or when the necessary treatment can only be carried out on an Inpatient basis. The treatment or care plan must be approved for Coverage through the Benefit Management Program. If Inpatient Care is not approved for Coverage or not found Medically Necessary according to Plan provisions, benefits will not be available. If private room used, charges more than the Average Semi-Private Room Rate will be excluded. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training. Refer to **Section I - Summary of Benefits** for benefit limits.

8. Substance Abuse Facility

Phone calls are required. Refer to **Section III - Benefit Management Program** for details. Alcohol abuse care is Covered under Hospital Expense benefits shown previously in this section.

- a. **Inpatient Care.** Benefits are available for Inpatient services rendered and billed by a certified Substance Abuse Facility (free-standing Inpatient facility or Hospital Inpatient center) for rehabilitation treatment of drug abuse. The Plan of Care must be approved for Coverage through the Benefit Management Program. The Provider must send a written treatment no later than 10 days after Inpatient Care begins. If treatment plan not sent within 10 days, benefits will not be paid. If Inpatient Care is not approved for benefits or is not found Medically Necessary according to Plan provisions, benefits will not be paid. Refer to **Section I - Summary of Benefits** for benefit limits. Private room charges are limited to the Average Semi-Private Room Rate, whatever the reason for its use. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training.
- b. **Outpatient Care.** Benefits are available for an Approved Plan of Care for Outpatient services rendered in a certified Substance Abuse Facility (freestanding agency or facility or a Hospital center) for the diagnosis and treatment of drug abuse. To be considered for benefits, the Claims Administrator must approve the Plan of Care for Plan Coverage. The Provider should send a written treatment plan before care begins or within 10 days after care begins. If treatment plan not received within 10 days, benefits will not be paid. If Inpatient Care is not approved for Coverage or is not found Medically Necessary according to Plan provisions, benefits will not be paid.

Each visit must consist of at least one of the following: individual or group counseling; activity

rehabilitation therapy; or diagnostic evaluations by a Doctor or other licensed professional to decide the nature and extent of the patient's Illness. Coverage includes limited benefits for Family Member counseling. Benefits are not payable for visits that consist primarily of participation in programs of a social, recreational, or companionship nature. The employees of the facility must render the services billed by the facility. Refer to **Section I - Summary of Benefits** for benefit limits.

5. **Ambulatory Surgical Facility.** Coverage is available for Allowable Fees billed by an Ambulatory Surgical Facility for their surgical services and supplies for Covered Surgery rendered for you or your Eligible Dependents.

9. Doctor Services

Some medical procedures require a phone call before rendered. Refer to **Section III - Benefit Management Program** for details.

Medical services rendered and billed by a Doctor are Covered for the following:

- a. **Surgery** benefits are available for Allowable Fees billed for surgeons' services when found Medically Necessary according to Plan provisions. When two or more procedures are done during the same operative session, the fees for the secondary procedures may be allowed at a reduced fee (usually 50% of allowable fee) to establish the Plan allowance for the operation. The surgical allowance includes the usual care given by the Provider before and after Surgery. Separate charges for care considered postoperative will not be paid. Separate charges for procedures or services considered part of, or incidental to, the surgical procedure will not be paid.
- b. **Assistant Surgeon** services will be Covered when such assistance is found Medically Necessary to do the surgical procedure. (A Hospital rule or requirement does not, in itself, establish Medical Necessity). The assistance must be in a Hospital or other facility where there is no qualified staff available to assist the surgeon. The Allowable Fees for the assistant surgeon will be based on 20% of the allowance for the surgical procedure.
- c. **General Anesthesia** services by an anesthesiologist when needed for a Covered surgical procedure are Covered. General Anesthesia services administered by the surgeon or assistant surgeon or by a Hospital employee are not available under the Plan. The General Anesthesia benefit includes the consultation before General Anesthesia service is given and usual care after Surgery. General Anesthesia for electro-shock therapy and non-surgical care is Covered when found Medically Necessary according to Plan provisions.
- d. **Maternity Services** rendered by a *Doctor* or a *certified nurse midwife* are Covered for childbirth or termination of Pregnancy, including abortion and miscarriage. The allowance for childbirth or termination of Pregnancy includes the usual care given before and after delivery by the same Provider. Benefits will be determined on the same basis as Surgery shown previously in this section. If another Provider renders partial care during the prenatal or postnatal period of total maternity care, benefits will be determined based on the type of care rendered.
- e. **Inpatient Physician Visits** during an approved stay in a Hospital or Skilled Nursing Facility are Covered except surgeons' post operative or post obstetrical care. The Physician in charge of the treatment for conditions other than Surgery or obstetrical care will usually be Covered for one visit per day under this benefit. Additional Physicians or Physician visits will be considered when found

Medically Necessary according to Plan provisions. For example: When patient's Illness is so critical or serious it requires more attention by the Doctor. Prolonged visit during critical period of Illness that requires constant bedside attendance by the Doctor will be limited to total of five hours per visit. The prolonged critical care visit must be found Medically Necessary according to Plan provision. Care by more than one Physician will be considered when each Provider gives medically required treatment for separate and different conditions. Benefits are not provided for Physician visits if care is Custodial.

- f. **Other Physician Evaluation and Management Visits** in the Physicians office, Outpatient Hospital or Skilled Nursing Facility, patient's residence (home or nursing home) or other Outpatient location will be Covered when found Medically Necessary according to Plan provisions. Mental Health Care is Covered separately under *Outpatient Mental Health Care* shown later in this section.
- g. **Specialist Consultation** is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Coverage is provided for Inpatient and Outpatient consultations and includes the specialist exam, necessary tests and written reports. The consultant must be a board-certified specialist whose specialty is appropriate to render an opinion for that person's condition. When the attending Physician requests the specialist opinion, benefits will be provided for as many opinion consultations as necessary. However, if the specialist takes over the management (treatment) of the condition, subsequent management visits are not considered consultations. When the attending Physician refers a patient to a specialist for the management (treatment) of an Illness or Injury, the visits are not considered consultations. The attending Physician must request the specialist consultation. The specialist exam will not be considered a consultation when referral is made by friends, relatives or by a Doctor who is not considered an attending Physician. If the specialist consultant is required primarily due to Hospital rules or regulations, benefits will not be paid.
- h. **Second Surgical Opinion Consultation** is Covered if you or your Eligible Dependents want to obtain a second opinion before proceeding with a Covered surgical procedure. A board-certified specialist whose specialty is appropriate to consider the need for that surgical procedure must render the second surgical opinion consultation. If the consulting Doctor renders the Surgery, consultation benefits are not available for the consultation. If the specialist consultant is part of the same Physician or specialty group of the Physician who first recommended the surgical procedures, consultation benefits are not available.

Some procedures require a phone call as part of the Benefit Management Program. Mandatory Second Opinion Consultation (SOC) that are arranged through this program could be eligible for Full Benefits. Refer to Section III - Benefit Management Program for details.

- i. **Radiation Therapy** rendered and billed by a Physician are Covered for non-Experimental treatment of an Illness or Injury.
- j. **Diagnostic X-rays and Machine Tests** are Covered when necessary for specific symptoms or related to specific Illness or Injury. Routine or preventive tests are not Covered unless specifically included otherwise in the Plan. Interpretation of a diagnostic x-ray done in the Hospital that has a written agreement with the Physician to provide this service is Covered. Benefits will be available for services billed by a Covered facility, clinic or Physician. Hospital charges for x-rays and machine testing are Covered under *Hospital Expense Benefits* shown previously in this section.
- k. **Diagnostic Lab and Pathology** tests are Covered when necessary for specific symptoms or related

to specific Illness or Injury. Routine or preventive tests are not Covered unless specifically included otherwise in the Plan. Benefits will be available for services billed by a Covered facility, clinic, Physician or independent lab. Hospital charges for lab and pathology are Covered under **Hospital Expense Benefits** shown previously in this section.

- l. Podiatry Services** by a licensed Doctor of podiatry are Covered for the treatment of an Illness or Injury of the feet. Coverage includes office visits, diagnostic services, surgical services and other usual care needed for the treatment of foot disorders. However, Plan excludes routine foot care; foot orthotics, shoe supports and other foot appliances; and certain chronic foot disorders. Refer to **Section VII - Plan Exclusions**. Exception: Routine foot care recommended by a medical Doctor related to the care of insulin dependent diabetic may be considered for benefits.
- m. Chiropractor Services** by a licensed chiropractor are Covered for active or Maintenance treatment of spinal subluxation. Coverage includes office visits, manual manipulation, diagnostic services and other usual care for this type of treatment. Plan Benefits are limited to \$ 750.00 per Calendar Year.

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. **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.

8. Professional Nursing

a. Private Duty Nursing

The charges for the first 48 hours of Covered Services for private duty nursing in a Calendar Year are excluded. Covered expenses will be reduced by these charges and Plan benefit determination will be based on the balance. The Plan excludes Inpatient private duty nursing.

Benefits are available for Outpatient private duty nursing ordered by a Physician and found Medically Necessary according to Plan provisions. Services must be provided by and require the skills of a registered professional nurse (RN) to manage the care of acutely ill patients and must not be ordered primarily at the request of a relative or Household Member. Benefits are not available for Custodial

Care or Maintenance Care or care that is primarily assistance with daily living or other services that do not require the skills of an RN. A licensed practical nurse may be allowed if the Doctor certifies that a registered nurse is unavailable for a portion or shift of 24-hour skilled nursing care. The Plan excludes the first 48 hours of Covered private duty nursing services. Inpatient private duty nursing is not Covered, whatever the reason. Refer to **Section I - Summary of Benefits** under *Major Medical Expense Benefits* for fee limitations and benefit limits.

- b. **Visiting Nurses.** Part-time or intermittent visiting nurse services are allowable when rendered in the patient's home and ordered by the attending Physician. Care must be billed by a certified visiting nurse agency or by a state or county visiting nurse service for professional nurse services.
- c. **Nurse Midwife Services.** Benefits are available for services by a certified licensed nurse midwife. The licensed registered nurse must be certified as a midwife and performing maternity services permitted within the scope and jurisdiction of his or her state midwife license. See maternity care under *Doctor's Services* shown previously in this section.

9. **Physical Therapy.** Benefits are available for physiotherapy by a licensed physical therapist of the type and duration ordered by the attending Physician. Therapy must be needed to restore body function lost due to an Illness or Injury. If you or your Dependent reaches maximum potential for significant and measurable improved function or if care is found by the Claims Administrator to be Maintenance Care, benefits will no longer be available. Exercise programs and use of body exercise equipment are not Covered.

Physical therapy is Covered, for example, when body function is lost due to conditions such as Accidental Injury, cerebrovascular accident, stroke, arthritis, multiple sclerosis or other progressive Illness. Physical therapy is not Covered, for example, when physical dysfunction is due to conditions such as mental retardation, spina bifida, developmental delay, autism, educational or occupational deficits or syndromes associated with perceptual and conceptual dysfunction.

10. **Speech Therapy.** Benefits are available for speech therapy by a licensed speech therapist when ordered by an attending Physician. Coverage is limited to speech therapy needed to restore Speech Function lost due to an Illness or Injury or to improve Speech Function following Surgery for correction of a birth defect that caused speech dysfunction. Congenital anomalies, brain dysfunction or developmental delays will not be paid. Speech therapy must be directed at significant and measurable restoration and improvement of Speech Function. If the patient reaches maximum potential for improved or age appropriate function, benefits will no longer be available. Speech therapy is not Covered for stammering, stuttering, lispings or mild articulation disorders. Benefits are not available for myofunctional or tongue thrust therapy.

Speech therapy is Covered, for example, when Speech Function is lost due to conditions such as a cerebrovascular accident, craniotomy, head Injury, meningitis, congenital anomalies corrected by Surgery (such as cleft lip or cleft palate), vocal cord nodules, or Surgery. Speech dysfunction due to medically documented chronic otitis media or middle ear infections during the formative years of speech that causes a delay in either speech or language (non acute, non recurrent otitis media does not meet these criteria) would be Covered. Speech therapy *is not* Covered, for example, when speech dysfunction is due to conditions such as psychosocial delays, mental retardation, spina bifida, autism, educational or occupational deficits, cerebral palsy, syndromes associated with perceptual and conceptual dysfunctions, dyslexia and attention deficit disorders.

11. **Durable Medical Equipment (DME)**

A phone call is required before DME rental or purchase when costs are expected to exceed \$100.00. Refer to **Section III - Benefit Management Program** under *Durable Medical Equipment Review* for details.

Benefits are available for the rental or purchase, if appropriate, of Durable Medical Equipment when ordered by an attending Physician and found Medically Necessary according to Plan provisions. Purchase will be allowable if the DME cannot be rented or when if rented equipment is needed for an extended period that would make the purchase less costly than continued rental. Equipment must customarily be used for therapy and suitable for home use. Coverage includes necessary supplies to operate the equipment. Examples of Covered DME are standard Hospital beds, respirators, canes, crutches, walkers, and wheelchairs. Such equipment, for example, does not include hearing aids, eyeglasses, contact lenses, blood pressure monitors, thermometers, shoes or other articles of clothing, communication devices, computers, air conditioners or purifiers, humidifiers, exercise equipment, comfort items or convenience items.

The necessary repairs and maintenance of purchased equipment will be allowed unless Covered by a warranty or purchase agreement. Duplicate DME is not Covered. Replacement of DME is Covered only when the existing DME is no longer serviceable due to change in body condition or is no longer repairable (wear and tear). Charges for delivery and service are not Covered. For additional limitations on this service, refer to **Section X - Definitions** under *Durable Medical Equipment*.

- 12. Prosthetics/Orthotics/Braces.** Benefits are available for purchase or repair of Prosthetics, orthotics and braces when ordered by a Doctor and found Medically Necessary according to Plan provisions. The devices or appliances must replace the function of physical organs, limbs or other body parts or must aid in their function. Coverage includes orthotics or braces needed to support or align movable parts of the body, prevent or correct deformities. However, the Plan excludes devices, supports or orthotics used for foot disorders, except when needed after open cutting surgical procedures.

Benefits are not payable for duplicate Prosthetics, orthotics or braces. However, replacement of Prosthetics, orthotics or braces will be Covered when the existing device or appliance is no longer serviceable due to change in body condition or is no longer repairable (wear and tear). Replacement of a device due to loss or theft is excluded. Purchase of biomechanical Prosthetics is excluded.

Examples of Covered devices or appliances are braces, post mastectomy breast Prosthetics (including surgical bras), cardiac pacemakers, artificial arms, legs and eyes used to replace or to support functioning parts of the body. *The initial contact lenses (or eyeglasses instead of contact lenses) and related exams are Covered when the contact lenses perform the function of the human lens and are medically required due to intra ocular Surgery, cataract Surgery or other absence of the organic lens. Contact lenses or eyeglasses prescribed for any other purpose are excluded. Hairpieces or wigs are Covered only when needed for hair loss due to chemotherapy or radiation therapy. The Plan will pay up to a maximum of \$250.00 for one hairpiece or wig per Lifetime. Hairpieces or wigs needed for any other purpose are excluded. Coverage does not include for example, hearing aids, computers, communication devices, cosmetic devices, dentures, other devices used in connection with teeth, temporomandibular joint appliances, foot orthotics, or devices otherwise excluded under the Plan.*

- 13. Medical Supplies (Self-care Home Use).** Benefits are available for certain medical supplies for self care home use when ordered by an attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not Covered. Medical equipment is Covered separately under *Durable Medical Equipment* shown previously in this section. Coverage is limited to the following medical supplies:

- a. Ostomy bags and supplies required for their use.
- b. Catheters and supplies required for their use.
- c. Syringes and needles necessary for conditions such as diabetes. Coverage also includes lancet, spring powered lancet pens and chemstrips for home testing by a diabetic person.

14. Ambulance. Benefits are available for emergency land ambulance transportation when found Medically Necessary, according to Plan provisions. Air ambulance is Covered only when the patient's condition was so serious that the patient could not be transported safely by land ambulance or if the location, from which the patient required emergency transportation, was inaccessible by land ambulance. Benefits are only payable for emergency transportation by professional ambulance or volunteer ambulance. Benefits are not payable if the patient could have been safely transported by any other means of transportation. **No other type of transportation or travel is Covered, whatever the reason.**

Coverage is provided for ambulance emergency services to the nearest Hospital that can treat the patient's condition. Emergency professional ambulance transportation to other locations may be considered based on patient's condition, reason for transfer, and Medical Necessity. For example, the Plan will not pay to have patient transferred to another Hospital when the primary reason is to be near his or her home. However, benefits would be allowed if the transfer was necessary because the first Hospital could not provide the necessary care and the patient required transfer to the nearest Hospital that could provide the needed care.

- a. **Professional or Hospital Owned Ambulance** services are Covered when ordered by a police officer or Physician for transportation to the nearest Hospital that can provide treatment for the patient's Illness or Injury. Professional ambulances are Hospital owned, government owned or private owned services operating within the jurisdiction and in accordance with state and local regulations for professional ambulances. The Claims Administrator, according to Plan provisions, will decide other professional ambulance transportation Coverage. See **Section I - Summary of Benefits** for benefit limits.
- b. **Volunteer Ambulance** transportation is Covered only when needed for transportation to the nearest local Hospital. Volunteer ambulance transportation is a service rendered by an organized volunteer ambulance operating within the jurisdiction and in accordance with state and local government requirements. You must submit a bill or proof of donation to the Claims Administrator. See **Section I - Summary of Benefits** for benefit limits.

15. Chemotherapy

A phone call is required before home care therapy begins. Refer to **Section III - Benefit Management Program** for details.

Benefits are available for chemotherapy services and supplies when ordered by the Doctor for non-Experimental treatment of an Illness or Injury. Coverage includes services, supplies and equipment for an Approved Plan of Care. When purchased at a Pharmacy, the chemotherapy drugs are generally available under *Prescription Drug Expense Benefits* shown later in this section.

16. Blood Transfusions. Transfusion services and supplies, including the cost of blood and blood products, only to the extent that such supplies could not be obtained without cost, are Covered when ordered by a Doctor and found Medically Necessary for non Experimental treatment of an Illness or Injury. Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled Surgery that customarily requires blood transfusions. Coverage includes services and supplies for obtaining, processing and storage

only to the extent that such services or supplies could not be obtained without cost.

17. **Oxygen and its Administration (Self-Care Home use).** Benefits are available for oxygen and the needed supplies for its administration when ordered by an attending Physician for self care home use. Oxygen must be found Medically Necessary, according to Plan limitations, for use in the treatment of severe hypoxemia (low oxygen levels in the blood) caused by chronic pulmonary conditions. For example: Chronic obstructive pulmonary disease, pulmonary fibrosis, congestive heart disease, pulmonary hypertension, and cystic fibrosis.
18. **Drugs and Medicines.** If this Plan is primary, refer to *Prescription Drug Expense Benefits* shown later in this section. If this Plan is secondary, Coverage becomes available under Major Medical Expense Benefits based on usual and customary charges. You must submit your claim for benefits to the primary Coverage, then to the Claims Administration for consideration. Benefits will be coordinated according to the rules shown in **Section VI - Coordination of Benefits**. Otherwise, drugs are Covered or excluded on the same basis as those shown under *Prescription Drug Expense Benefits*.

E. MISCELLANEOUS PROVISIONS

1. **Voluntary Sterilization.** Hospital Expense Benefits and Major Medical Expense Benefits are available for Allowable Fees relating to voluntary sterilization procedures rendered for you or your eligible Spouse. Expenses related to reversal of voluntary sterilization are not Covered.
2. **Artificial Conception.** Coverage is limited to artificial insemination when needed due to a medical condition of the patient or due to abnormal male (Spouse of the patient) factors contributing to infertility. Coverage is available up to a maximum of six ovulatory cycles per course of treatment when rendered within two consecutive years. The course of treatment must be pre-approved for Coverage by the Claim Administrator. To obtain Coverage approval for a course of artificial insemination, the Doctor must provide statement of Medical Necessity including details on condition, medical history, previous infertility or artificial insemination treatment and proposed treatment Plan. The Claims Administrator will advise whether Coverage is available according to Plan limitations and exclusions. Benefits are limited to the following:
 - a. Initial course of artificial insemination up to six ovulatory cycles within two years.
 - b. If the treatment course is not successful (does not result in confirmed Pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent artificial insemination expenses.
 - c. If the initial course of treatment is successful (results in confirmed Pregnancy) within six cycles, Coverage becomes available for a second course of artificial insemination treatment when pre-approved for Coverage by the Claims Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent artificial insemination treatment.
 - d. Exhausted Coverage or benefits is for a Lifetime.

Benefits for the resulting Pregnancy will be considered separately as maternity care. However, expenses related to surrogate maternity care are not Covered. Expenses related to the procurement of sperm donated by the patient's Spouse are Covered only when part of an approved course of treatment for artificial insemination. If services are not part of an approved course of treatment, the procurement expenses are not Covered, whatever the reason. All expenses related to sperm procurement from a donor other than a Spouse are not Covered, whatever the reason. Coverage is not provided for the infertility or artificial conception services and supplies related to surrogate pregnancies. Expenses related to the freezing and storage of sperm are not Covered, whatever the reason.

Reproductive Coverage is limited to artificial insemination shown above. **Coverage is not provided for other care such as in-vitro fertilization; fertility or infertility care or any other treatment rendered for the purpose of reproduction.** However, surgical or medical procedures directed at treatment of an identifiable organic disease or organic disorder will be considered the same as any other Illness.

10. **Dental Care.** Coverage for dental care is limited to treatment of damage to sound natural teeth due to non-occupational Accidental Injury. Treatment must be rendered within 12 months following the date of the accident. **No other dental care is Covered.** Procedures rendered by a dentist that would otherwise be considered medical if rendered by medical Doctor will be considered medical expenses Covered by the Plan. These procedures include, but are not limited to removal of tumors, treatment of cancer, fractures of jaw, tongue Surgery, etc. However, the Plan does not provide benefits for procedures that are dental only such as simple or surgical extraction of teeth, orthodontia, treatment of cavities, treatment of periodontal disease, false teeth, etc. even if connected with the medical procedure.

F. PRESCRIPTION DRUG EXPENSE BENEFITS

Secondary Coverage. The PCS Health Systems Pharmacy benefit or PCS 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.

You and your Dependents may purchase drugs from any Pharmacy. However, if this Plan is considered the primary payer and you or your Dependents choose a PCS Participating Pharmacy or use the PCS Mail Service for maintenance drugs, you save costs for yourself and the District.

- 1. Covered Prescription Drug Expenses.** The maximum quantity of each Covered drug purchased at one time will be limited to a 34-day supply or 100 doses. Mail service drugs will be limited to a maximum quantity of a 90-day supply. Prescription refills will be paid for up to one (1) year from the date of the original prescription. Unless otherwise shown, all drugs must be ordered by the attending Physician and found Medically Necessary.
 - a. Medications that require a prescription by a licensed Physician and are Federal legend drugs.
 - b. Compounded medications containing at least one prescription ingredient in therapeutic amounts.
 - c. Diabetic insulin, syringes, lancet auto-injectors, and lancets.
 - d. Injection delivery devices (syringes) for uses other than diabetic when necessary for self-administration of Covered injectable legend drugs.
 - e. Tretinonoin topical for Medical Necessity with a prescription. Pre-authorization is required for Covered Persons.
 - f. Prenatal vitamins or other vitamins obtainable only with Physician's prescription.
 - g. Allergy emergency kits for emergency treatment of insect stings in allergic patients.
 - h. Drugs for treatment of impotency, Caverject, Muse, Edex and forms of testosterone used for treatment of impotence. Sildenafil Citrate (Viagra or similar drug) when pre-authorized through POMCO. A written request for Viagra pre-authorization should be sent to the POMCO Benefits Management department with attending Physician's statement showing Medical Necessity.
 - i. Other drugs that under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

Except for diabetic insulin and supplies, drugs and medicines purchased without written orders from the attending Physician are not payable. Also, refer to prescription drug exclusions shown later in this section.

- 2. Voluntary Generic Drug Substitution Program.** As part of a continuing effort to control costs and preserve the quality of the Plan, you 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.
- 3. When Another Plan is Primary.** If another health plan is considered primary coverage according to the COB order of benefit determination, Prescription Drug Expense Benefits are not available. If this Plan is secondary, do not show your Plan identification card, do not obtain benefits through PCS. Do not obtain

drugs through the mail service Pharmacy. If this Plan is secondary, you will be required to reimburse any benefit overpayments resulting from using PCS or the mail service Pharmacy.

4. **Participating Pharmacy.** A Participating Pharmacy has an agreement with the prescription drug Claims Administrator, PCS 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 PCS Participating Pharmacies. If a PCS Pharmacy is used, you will be required to pay only the following Copayments:

- a. **Copayments:**

For Specific Drugs Listed:

\$7.00 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: \$ 3.00 for each prescription or refill.

Brand Name: \$ 10.00 for each prescription or refill.

- b. **Plan Identification Card.** You can use your Plan identification card at any PCS Participating Pharmacy. The Pharmacy may display the PCS participation logo or you may ask the Pharmacy if it participates as a PCS 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 PCS Participating pharmacist, then pay the applicable Copayment amount. The Pharmacy will bill PCS directly and will receive direct payment from them. If you do not present your Plan identification card at the time of purchase, you must file your own claim and benefits will be allowed as if the drug was purchased at a Nonparticipating Pharmacy. Refer to ***Nonparticipating Pharmacy*** shown later in this section.

Questions or concerns about the drug program can be answered by POMCO. You may contact them by calling the POMCO Toll-free number 1-800-303-8381 during normal operating hours or send a written inquiry.

5. **Nonparticipating Pharmacy.** If this Plan is primary and you or your Dependents purchase Covered drugs at a Nonparticipating Pharmacy (or do not use your Plan identification card), you must pay the Pharmacy and submit a claim for benefits to PCS. Benefits will be based on the PCS Participating Pharmacy allowance the Covered drugs less the specific drug, generic or brand name Copayment shown above. You will be responsible for payment of charges more than the PCS allowance. To file a claim for benefits, a drug claim form must be obtained from the District Personnel Office. The original drug receipt (receipt should include dates of purchase, names of drug, dose and Rx #.) and the completed drug claim form should be mailed to:

**PCS Health Systems
P. O. Box 52116
Phoenix, Arizona 85072-2116**

6. **Mail Service for Maintenance Drugs.** If this Plan is primary, you or your Dependents may obtain maintenance drugs from PCS Health Systems Mail Service, mail service. After applicable Copayment shown below the Plan pays the balance of Participating mail service fees for Covered drugs. This service delivers the drug directly to your home. Maintenance drugs are medications that are taken for chronic conditions such as hypertension, heart disease, thyroid disease and diabetes. In addition, acute care medications with prescriptions

written for more than 21 days (one refill) may be obtained through the mail service. After applicable copayments, the PCS 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: \$ 1.00 Copayment for each prescription or refill.

Brand Name: \$ 5.00 for each prescription or refill.

b. How to Use the Mail Service Pharmacy Program

- 1) When the Physician writes a prescription for a "maintenance drug" (one taken regularly or on a long-term basis) he or she should indicate the number of refills allowed (maximum 3 refills).
- 2) For your first mail service order, complete the supplied patient profile/registration form. Enclose the completed form in the self-addressed envelope with the original prescriptions written by the Physician, then mail to the mail service Pharmacy.
- 3) For original and refill prescriptions, complete the supplied order form. A new order form and envelope will be included with each delivery.
- 4) The medication will be delivered to you or your Dependent by first-class mail or UPS. You should allow 10-14 working days from the time the prescription forms are mailed to the mail service Pharmacy until delivery of your medication. **However**, to ensure that you or your Dependents are not left without an adequate supply of medication, you should order when you or your Dependents have a minimum of a 30-day supply of the current medication. Drugs cannot be filled at a retail Pharmacy while mail order is being processed.

PCS Health Systems Mail Service

PO Box 961066

Fort Worth, TX 76161-9854

1-800-966-5772

7. Prescription Drug Expense Exclusions. In addition to limitations shown otherwise in the Plan, the following drugs or supplies are not Covered under Prescription Drug Expense Benefits. See also **Section VII - Plan Exclusions** shown later in this SPD.

- a. Non-Legend drugs/over the counter (drugs obtainable without prescription), unless otherwise shown. Exception: Drugs specifically included for Coverage under this benefit.
- b. Weight loss drugs, anti-obesity/appetite suppressants.
- c. Contraceptives or birth control medicines, drugs or devices.
- d. Implantable time-released medication (i.e., Norplant)
- e. Therapeutic/diagnostic devices and appliances unless specifically shown as Covered Prescription Drug Expenses.
- f. Cosmetic medication including but not limited anti-wrinkle medications, dermatological medications, hair growth medications, any drugs FDA approved for cosmetic use only.
- g. Immunization agents, vaccines, allergy extracts and blood or plasma.
- h. Vitamins, Minerals, food supplements or nutritional products that are obtainable without a prescription.

- i. Growth hormones.
- j. Drugs labeled “Caution-limited by federal law to investigational use”, Experimental drugs or drugs prescribed for Experimental (non FDA approved/unlabeled) indications
- k. Fluoride prep and dental rinses.
- l. Smoking deterrents whether or not by Physician prescription.
- m. Charges for the administration of any medication.
- n. Medication which is to be taken by or administered to an individual, in whole or part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Skilled Nursing Facility, Extended Care Facility, Convalescent Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- o. Drugs that are not considered Medically Necessary for treatment of an Illness or Injury even if obtainable only by prescription and even if prescribed by a Physician.

SECTION V - MEDICARE INTEGRATION WITH PLAN BENEFITS

If Medicare is primary, Plan benefits will be reduced by Medicare benefits. Medicare primary plan status is determined according to Medicare Secondary Payer (MSP) rules established by government regulations. Revisions or changes in these MSP rules will automatically apply. *If you or your Dependents are eligible for Medicare primary benefits, claims should be submitted to Medicare first. Medicare explanation of benefits should be attached to your claims for this Plan.* Refer to "Your Medicare Handbook" for information and details on Medicare coverage. This handbook can be obtained at your local Social Security Office.

You or your Dependents are responsible for Medicare enrollment. If you or your Dependent does not hear from the Social Security Office at least three months before a 65th birthday or within 12 months after starting Social Security disability benefits, you or your Dependent should call your local Social Security office for assistance. Persons who have end stage kidney disease should contact the Social Security Office for eligibility and enrollment details. If this Plan is primary Coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to Medicare Secondary Payer rules. Your local Social Security Office can provide details on enrollment requirements and penalties for late enrollment.

This Medicare integration provision applies to all persons eligible for primary Medicare coverage even if the person is not actually enrolled in Medicare. If not enrolled for primary Medicare coverage, Medicare benefits will be estimated. When enrolled for primary coverage under a Medicare-sponsored HMO plan, no payment will be made if the HMO benefits are denied due to failure to follow the HMO procedures for coverage.

A. MEDICARE SECONDARY PAYER (MSP) CURRENT RULES

Currently, the following general MSP rules apply for persons eligible for Medicare:

- 1. Persons Eligible for Medicare due to age (65 and over) or Due to Disability**
 - a. Medicare is secondary to the plan that covers this person as a person with current employment status, or the Dependent of a person with current employment status.
 - b. Medicare is primary to the plan that covers this person as a retiree or a person without current employment status, or the Dependent of a retiree or a person without current employment status.
- 2. Persons Eligible for Medicare due to End Stage Renal Disease (ESRD).** Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare coverage is not limited to ESRD expenses.
 - a. Medicare Eligibility Solely Due to ESRD**
 - 1) 18-Month Rule.** Before July 31, 1997, Medicare is secondary for the first 18 months following the month of the ESRD eligibility date for persons eligible solely due to ESRD. If an ESRD eligible person did not complete 18 months of ESRD eligibility before August 1, 1997, the following 30-month rule applies.
 - 2) 30-month Rule.** On or after August 1, 1997, Medicare is secondary for the first 30 months following the month of the ESRD eligibility date for persons eligible solely due to ESRD. The 18-month rule is extended to 30 months for persons who did not complete 18 months of ESRD

eligibility on or before July 31, 1997. This 30-month rule does not apply if the Covered Person completed 18 months of ESRD eligibility before August 1, 1997.

- b. Medicare ESRD Dual Eligibility.** ESRD dual eligibility means a person who is eligible for Medicare due to age and ESRD or due to disability and ESRD. Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare benefits are not limited to ESRD expenses.
- 1) If a group plan is appropriately paying secondary to Medicare according to MSP rules for eligibility due to age or disability and ESRD entitlement then becomes effective, Medicare remains the primary payer. The 18-month or 30-month ESRD period does not apply.
 - 2) If the group plan is paying primary according to MSP rules for eligibility due to age or disability and then ESRD entitlement becomes effective, Medicare remains secondary until after the 18-month or 30-month ESRD period. At the end of the 18-month or 30-month ESRD period, the group plan becomes primary or secondary payer based on the MSP rules for age and disability.
 - 3) If a group plan is paying primary to Medicare according to MSP rules for ESRD, and then the person becomes eligible due to age or disability, Medicare remains secondary until the end of the 18-month or 30-month ESRD period. At the end of the 18-month or 30-month ESRD period, the group plan becomes primary or secondary payer based on the MSP rules for age and disability.

B. EFFECTS OF MEDICARE ON PLAN BENEFITS

If Medicare is primary for you or your Dependent, the benefits of the Plan will be integrated as follows:

1. **Medicare Payment Integration.** Medicare payment for Covered expenses will reduce the Allowable Fees then the Plan benefit determination will be based on the balance, if any. The Plan Deductibles and Copayments apply to the remaining balance. The combination of the Medicare payment and the Plan payment will not exceed the Allowable Fees for the Covered service.
2. **Not Enrolled in Medicare.** This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare. If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits.
3. **Medicare Private Contract Options.** This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain Providers, Medicare will not pay. The patient is responsible for the entire charge. The Provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Medicare Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated based on 80% of Usual, Customary and Reasonable Charges for Covered Services or Supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.
4. **Medicare HMO.** This integration will not apply when Medicare and a Medicare sponsored HMO deny coverage due to its enrolled beneficiaries failure to abide by the HMO requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

C. ALLOWABLE FEES

Allowable Fees for Medicare integration only will be based on the following:

1. If the Provider accepts Medicare assignment of benefits, the Allowable Fees will be the same fees allowed by Medicare.
2. If the Provider does not accept Medicare assignment, the Allowable Fees will be based on the Usual, Customary and Reasonable Charges or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.
3. If the Provider provides services under a Medicare Private Contract Option, Allowable Fees will be based on the Usual, Customary and Reasonable Charges for services Covered by this Plan.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option, the Provider's charges can exceed the Medicare Allowable Fees.

SECTION VI – COORDINATION OF BENEFITS (COB)

Information necessary to administer the COB provision will be required when claims are submitted. If you or your Dependents are covered by more than one plan, *all claims should be filed with each plan*. You should file claims first with the primary plan, then to the secondary plan(s) with copies of the primary plan explanation of benefits or denial.

Special rules apply when you or your Covered Family Members are covered by more than one group health plan. This can happen if you, your Spouse, and/or children are Covered under This Plan and another plan (with your Spouse's employer, for example). Coordination of Benefits (COB) means that the benefits payable under This Plan, as shown in the preceding pages, are coordinated with the benefits payable under another group plan. The purpose of COB is to avoid duplicate payments that could exceed 100% of the total allowable expenses.

One of the two or more plan(s) involved is the primary plan and the other plan(s) is the secondary plan(s). The order of benefit determination shown later in this section determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. The secondary plan pays after the primary plan and may reduce its benefits so that payments from all involved plans do not exceed 100% of allowable fees.

A. COB TERMS AND DEFINITIONS

The following definitions show the meaning of terms used in the administration of this COB provision.

1. **This Plan.** Whenever the term “This Plan” is used in this section, it means this Bedford/Carmel School District Health Benefit Plan for Bedford Central Schools.
2. **Plan.** The term ‘plan’ includes any of the following:
 - a. A group insurance or group type coverage, whether insured or uninsured, including, but not limited to, coverages such as prepayment; indemnity; Hospital or medical service organizations; group practice or individual practice; health maintenance organizations or similar type organizations; group auto plan or individual auto health coverage on an automobile leased or owned by an employer; student coverage sponsored by, or provided through, a school or other educational facility except school accident type coverage.
 - b. Coverage under a governmental plan, or coverage required or provided by federal, state, or local laws. This does not include government coverage such as Medicaid, that by its terms, prohibits coordination for the allowable expenses. This Plan integrates its benefits with Medicare. See **Section V - Medicare Integration with Plan Benefits**. This Plan excludes expenses paid by mandatory no-fault automobile insurance or similar plans. These expenses will not be coordinated under this provision.

Each contract, policy or other arrangement for coverage under a or b shown above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one, each part is a separate plan.

3. **Primary Plan/Secondary Plan.** The order of benefit rules determines whether This Plan is a primary or secondary plan to another plan covering the person. When This Plan is primary, its benefits are determined before those of the other plan and without regard to the other plan benefits. When This Plan is the secondary plan, its benefits are determined after those of the other plan and may be reduced because of the primary plan

benefits. If a person is covered by more than one secondary plan, the order of benefit rules determine the order in which secondary plans are determined in relation to each other. Each secondary plan will take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the order of benefit rules, has its benefits determined before those of that secondary plan.

4. **Claim Determination Period.** The claim determination for coordination of benefits is done on an Incurred expense basis. However, it does not include any Allowable Fees Incurred during any part of a Calendar Year during which a person has no Coverage under This Plan, or any part of the year before the date this COB provision takes effect.
5. **Allowable Expense.** The term ‘allowable expense’ means medical care expenses, including deductibles and copayments or coinsurance, that are covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of medical services (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or services that is not covered by any of the plans will not be considered an allowable COB expense. The following are examples of expenses not considered allowable expenses or otherwise limited under this COB provision:
 - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room and the private room is not an allowable expense unless the private room is found Medically Necessary according to This Plan’s provisions or the primary plan routinely includes coverage for Hospital private rooms.
 - b. If a person is covered by two or more plans that determine benefit payments based on Usual, Customary and Reasonable (UCR) Charges, any amount more than the highest of the UCR charges for the specific medical benefit is not an allowable expense.
 - c. If a person is covered by two or more plans that provide benefits or services based on negotiated fees, any amount more than the highest of the negotiated fees for the specific medical benefit is not an allowable expense.
 - d. If a person is covered by one plan that determines its benefits based on Usual, Customary and Reasonable Charges and another provides benefits or services based on negotiated fees, the primary plan’s payment arrangements will be the allowable expense for all plans.
 - e. The amount benefits are reduced by the primary plan because a Covered Person does not comply with the plan provisions is not an allowable expense. Examples of these provisions include, but are not limited to, mandatory requirements of a benefit management program, second surgical opinions, medical procedure review, pre-certification of Inpatient admissions, pre-approval requirements for certain treatment, and HMO or preferred Provider arrangement.
 - f. As secondary payer, long term care, dental or vision or hearing aid expenses excluded under This Plan will not be considered allowable expenses, even if such expenses were covered by the primary plan.
 - g. As secondary payer, This Plan will not consider any health benefits paid due to mandatory no-fault laws as allowable expense for COB. However, charges for health expenses applied to no-fault plan deductibles, copayments or more than the cumulative benefit maximum per accident will be considered as allowable expenses, if otherwise Covered by This Plan.
 - h. If Medicare is primary, charges more than the allowable expenses permitted under Medicare regulations

will not be considered allowable expenses for COB.

B. ORDER OF BENEFIT DETERMINATION

If a Covered Person is eligible for Medicare, the order of benefit determination can be affected by Medicare Secondary Payer (MSP) rules. Current MSP rules and any future change in the MSP rules will automatically apply. Rule # 4 shown below applies if you or your Dependent are continuing Coverage under COBRA.

The order of benefit determination rules shown below determines which plan pays first. The primary plan pays first without regard to the possibility that another plan could pay some expenses. A secondary plan pays after the primary plan and reduces its available benefits so that payments from all involved plans do not exceed 100% of the total allowable expenses.

This Plan is always secondary payer to any health plans that pay without regard to coverage by other plans. This Plan is always secondary to government plans or coverages provided by federal, local, or state laws unless otherwise prohibited by that law. For example: This Plan is secondary to New York State mandatory no-fault automobile plans. However, this Plan could be secondary payer according to Medicare's Secondary Payer rules. To determine the order plans should pay for expenses covered by two or more plans with a COB feature, an order of benefit determination has been established as follows:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, for example as an employee, member, subscriber, enrollee, or retiree is primary. The plan that covers the person as a Dependent is secondary. (However, this changes if the person is eligible for Medicare primary benefits. The Medicare rules for with and without employment could apply making the Dependent plan primary over the plan of the employee without employment status.)
2. **Child Covered under More than One Plan.** The following order of benefits is used when a child is covered by more than one Plan.
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year if the parents are married, not separated (whether or not they have ever been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - b. When specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
 - c. If the parents are not married, or are separated (whether or not they have ever been married), or are divorced; the order of benefits is the plan of the custodial parent, then the plan of the Spouse of the custodial parent, then the plan of the non-custodial parent and then the plan of the Spouse of the non-custodial parent. The custodial parent is the parent awarded custody by a court decree. Without a court decree, it is the parent with whom the child resides more than half the Calendar Year without regard to temporary visitations.
3. **Active/Inactive Employee.** The benefits for a plan that covers a person as an employee who is neither laid off nor retired are determined before the plan that covers that person as a laid off or retired employee. The same

would hold true for Dependents covered under that person's family Coverage.

- 4. Continuation of Coverage.** If a person elects or is covered under continuation of coverage pursuant to federal or state laws, such as COBRA, and is also covered under another plan, the order of benefit rules change. The plan providing coverage for the individual as an employee, member, subscriber, enrollee, or retiree is primary for that person and/or that person's dependents. The plan providing continuation coverage is secondary.

If the preceding order of benefit rules fail to establish the primary plan(s), then the plan that has covered the patient for the longer time will consider its plan benefits first. If according to the above rules, This Plan is secondary and another health plan's rules conflict making This Plan primary, This Plan will use the National Association of Insurance Commissioners (NAIC) Model Regulation and any court cases to determine the validity of the conflicting rules.

C. MEDICARE EFFECT ON THE ORDER OF BENEFIT DETERMINATION

Please refer to "Your Medicare Handbook", obtainable from your local Social Security Office, for details on current Medicare Secondary Payer (MSP) rules. Also, see **Section V - Medicare Integration with Plan Benefits**. Generally, if Medicare is considered primary coverage, the order of benefit determination could be changed for the other multiple health plans as follows:

1. For individuals eligible for Medicare due to age (65 or over) or due to disability who are covered under a plan as a person with current employment status, or a Dependent of a person with current employment status, the following order of benefit determination applies:
 - a. All active plans (employees with current employment status and their eligible dependents) pay first.
 - b. Medicare pays second.
 - c. Retired plans, or employees without current employment status plans, pay last.
2. For individuals eligible for Medicare solely due to ESRD, the order of benefit determination is as follows:
 - a. Medicare pays last for the first 30 months following the month of first eligible ESRD treatment. Usual order of benefit determination would apply for other group plans.
 - b. Medicare pays first after the first 30 months. Other plans would be secondary following the order of benefit determination.

D. COB EFFECT ON PLAN BENEFITS

When this Plan is secondary, benefits will be reduced so that the total benefits paid or provided by all plans are not more than 100% of the allowable expenses Incurred during a claim determination period. When benefits are so reduced, each benefit is reduced in proportion and applied against any applicable benefit limit of the Plan.

When this Plan is secondary, payment could be reduced if the benefits available for the Covered Expenses under this Plan (without this COB provisions) and the benefits payable by all other involved plans are more than 100%. Then, the benefits of This Plan will be reduced so that they, and the benefits payable under the other plan(s), do not total more than the total allowable expenses Incurred during a claim determination period. When the benefits of This Plan are so reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

If a Covered Person fails to file a claim with the primary payer, benefits for the primary plan will be estimated. When this Plan is secondary to multiple health plans and one is Medicare, the benefits paid by all primary plans, including Medicare will be used to determine the benefit reduction under this COB provision. If the person is not enrolled in primary Medicare coverage, the Medicare benefits will be estimated. If a claim has not been filed with the other primary plans, their benefit will be estimated. Estimated benefits will be used to determine this Plan payment under COB.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Claims Administrator may get the facts it needs from, or give them to, any other organization or person for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person for whom claim is made. The Claims Administrator need not tell, nor get the consent of, any person to do this. Each person claiming benefits under the Plan must give the Claims Administrator any facts required to pay the claim.

F. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may pay the amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under the Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided as services.

G. RIGHT OF RECOVERY

If the amount of the payments made by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The enrollee, Dependent for whom it has paid or the Provider to whom benefits were paid.
2. Insurance companies;
3. Self-Funded claims administrators; plan administrators, or plan sponsors; or
4. Other organizations or entities.

H. EXAMPLES OF COB ORDER OF BENEFITS

1. I am eligible for District Plan benefits as an active Employee and am also eligible as a retiree under the ABC Mfg. health plan. (I am not eligible for Medicare). Which plan pays first?

Your active Plan with the District is primary over your retired plan. The District Plan would pay first.

2. I am eligible for the District Plan benefits as a retired Employee. My Spouse covers me as a Dependent under her employer's health plan. My Spouse is an active employee of XYZ, INC. I am not eligible for Medicare due to age or disability. Which plan pays first for my health claims? For my Spouse's health claims?

- a. **Health Claims for yourself:**
The District Retired Plan pays first

XYZ, INC Active plan pays second

b. Health Claims for Spouse:

XYZ, INC active plan pays first

The District retired Plan pays second

3. I am eligible for Plan benefits as an active Employee and also eligible as a retiree under the ABC MFG health plan as a retiree. I have family Coverage under both plans. My Spouse also covers our Dependent children and me under his or her group plan through XYZ INC. (We are not eligible for Medicare) My birth date is July 10, 1950. My Spouse was born June 15, 1951. What is the order of benefit determination for myself, my Spouse and my children?

a. Health Claims for yourself. Your Health plan would pay before the health plan of your Spouse.

Order of benefit determination is:

The District active Plan pays first.

ABC Mfg. retired plan pays second.

XYZ INC Active plan for Spouse pays last

b. Health Claims for Spouse. Your Spouse's plan pays before your health plans. Order of benefit determination is:

XYZ INC. Active plan for Spouse pays first

The District active Plan pays second

ABC MFG. retired plan pays last

c. Health Claims for Dependent Child. The order of benefit determination is based on the earliest birthday (month/day) of the child's parents. The plan(s) of the parent with the earliest birthday pays before the plan(s) of the parent with the later birthday. As your Spouse's birthday (June 15) is the earliest date, the order of benefit is:

XYZ INC Active plan of Spouse pays first

The District active Plan pays second

ABC MFG Retired plan pays last.

The above order of benefit applies to children whose parents are not separated or divorced.

4. I am eligible for the District benefits as a retiree and I am also eligible for Medicare Benefits due to age. Does Medicare or the District pay first?

In accordance with Medicare Secondary Payer rules, Medicare would pay first.

5. I am eligible for the District benefits as a retiree and I am also eligible for Medicare benefits due to age. In addition, I am eligible for benefits as a Dependent under my Spouse's health plan through her/his employer, XYZ INC. My Spouse is an active employee.

The order of benefit determination rules can change due to Medicare rules. According to Medicare Secondary Payer rules, Medicare pays after active (with employment status) employee plans for persons eligible for Medicare due to age or disability. The active plan(s) covering a person as an employee or a Dependent must pay before Medicare. The order of benefit for health claims on yourself would be:

XYZ Active plan of Spouse would pay first

*Medicare would pay second
The District retired Plan would pay last.*

6. I am eligible for the District continuation Coverage under COBRA, and Medicare due to age. I am also eligible under the retiree Plan of my Spouse through XYZ, Inc.

The order of benefit determination rules can change due to Medicare Secondary Payer rules. According to MSP rules, Medicare (due to age) pays before plans for persons without employment status. (Continuation Coverage pays after other Health Plans).

*Medicare Pays first.
XYZ, Inc. Retired Plan pays second.
The District continuation under COBRA pays last.*

7. I am eligible for the District benefits as an active Employee. My Spouse is eligible for benefits through his/her employer, XYZ INC. We both include our Spouse as an eligible Dependent. My Spouse is eligible for Medicare due to end stage renal disease. What is the order of benefit determination for my Spouse's claims?

Current Medicare Secondary Payer rules establish the employer health plans as primary payer for the first 30 months of Medicare Eligibility due to end stage renal disease. Medicare becomes primary payer after the first 30 months.

*The order of benefit determination for the **first 30 months** would be
XYZ INC. Spouse's plan pays first
The District Plan pays second
Medicare pays last*

*The order of benefit determination **after 30 months** would be
Medicare pays first
XYZ INC Spouse's plan pays second
The District pays last.*

SECTION VII - PLAN EXCLUSIONS

All benefit determinations are based on Plan limitations and exclusions in effect at the time expenses are Incurred. All claims are subject to review to decide whether services are Covered, according to Plan limitations and exclusions. You must comply with requests for additional medical documentation, as deemed necessary by the Claims Administrator, to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. **Treatment decisions are independent from payment decisions.** The patient's Physician is responsible for deciding whether treatment should be rendered despite whether the charges are totally or partially included in or excluded from Coverage under the Plan. If any of the entities used to determine the Medical Necessity or the Investigative nature of a drug, device, supply, treatment or any other medical service, reverses, modifies, or establishes its policy for such expenses and makes such changes retroactive, the Plan will not make payment for such retroactive Incurred Expenses. The Plan will not seek refunds for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

In addition to limitations and exclusions shown elsewhere in this SPD, charges for the following expenses **will not** be paid by the Plan, unless specifically shown otherwise for Plan Coverage. Also, please refer to **Section X - Definitions**.

1. **Plan Coverage not in Effect.** Services or supplies Incurred while an individual is not enrolled and eligible in the Plan or Incurred before the Plan became effective or after the Plan is canceled. Services or supplies that are not Covered according to Plan limitations and exclusions in effect at the time expenses were Incurred.
2. **Unreasonable Charges.** Charges that are more than any fees found usual, customary, and reasonable according to Plan provisions.
3. **Not Physician Approved/Not under Care of Physician.** Services or supplies not recommended or approved by a Physician or dentist, received while not under the care and treatment of the ordering Physician or dentist, or services not rendered by a Covered Provider.
4. **Medical Necessity.** Services or supplies that are not Medically Necessary according to Plan provisions for the treatment of an Illness or Injury. Preventive care or well care such as routine physicals, screening exams, premarital exams, school exams, camp or sport exams, screening exams, and related services are not Covered. Tests unrelated to symptoms or treatment of Illness or Injury, inoculations, immunizations, vaccinations, or other preventive shots are not Covered. Exception: Care specifically included under ***Preventive Care Expense Benefits***, or voluntary sterilization expenses.
5. **Blood Donations.** Services or supplies for autologous or directed blood donations and/or storage when done as precautionary measure in case the need for blood arises. Exception: Autologous or directed donation services and supplies preceding Surgery as specifically included in the Plan.
6. **Investigative or Experimental /Acupuncture/Alternative Care.** Services or supplies related to care considered Investigative or Experimental, according to Plan provisions, at the time expenses are Incurred. Refer to **Section X - Definitions** under ***Investigative or Experimental***. Transplants will be considered Investigative, except those that are specifically covered by and meet the Federal Health Care Financing Administration coverage criteria in effect at the time expenses are Incurred. Services or supplies connected with care such as acupuncture, holistic medicine, hypnotherapy, environmental ecology, and

other alternate type medicines are not Covered.

- 7. Drugs/Infertility/Birth Control/Vitamins/Supplements.** Medicines or drugs that can be purchased without a Physician's prescription, contraceptive (birth control) drugs and devices, infertility drugs, or vitamins and supplements, including nutritional supplements or food products, whether or not obtainable by prescription. Exceptions: Insulin, in-vitro fertilization, artificial insemination expenses, and other drugs specifically included as Covered Expenses under *Prescription Drug Expense Benefits*.
- 8. Home Medical Supplies.** Medical supplies for home use that are not directly supplied by professional home care services, or that is not for the operation of Covered Durable Medical Equipment. Items primarily intended for comfort or to support activities of daily living, such as diapers, ice bags, incontinent pants, support stockings, nutritional supplements, cervical or lumbar pillows. Exception: Covered colostomy supplies, catheters and related supplies, Covered syringes and needles for conditions such as insulin dependent diabetes, or certain supplies for diabetics specifically included as Covered Expenses.
- 9. Personal Items.** Personal comfort items such as telephone, radio, television or barber services charged by any facility or other Provider.
- 10. Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices; or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction. The purchase of Durable Medical Equipment that can be rented unless the length of time the equipment will be needed makes the purchase of such equipment less costly than the rental. The purchase or replacement of any biomechanical prosthetic device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, orthotics or splints used primarily for athletic use.
- 11. Vision.** Services or supplies related to vision therapy, visual aids, eyeglasses or contact lenses, or their repairs, and related examinations to decide the need for, adjustments or repair of them. Surgical treatment for the correction of a refraction error, including radial keratotomy when corrective lens may be worn. Exception: Services specifically included in the Plan such as initial contacts following cataract or other intra-ocular Surgery, lenses for aphakia and soft lenses or sclera shells intended for treatment of disease or Injury.**Hearing.** Services or supplies related to hearing aids, tinnitus masking devices, (or similar devices), communication devices, and related examinations to decide the need for, adjustments or repair of them.
- 12. Family Counseling.** Counseling and consultation services with members of the family other than the patient. Exception: Family member counseling under Plan Coverage for alcohol abuse and substance abuse and bereavement counseling under Hospice Agency care.
- 13. Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process (dental work), such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered dental in nature. Exception: Charges by a dentist for care otherwise considered medical such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, freeing of muscle attachments, or care rendered for Accidental Injury to sound natural teeth within 12 months after the date of accident.
- 14. Temporomandibular Joint Syndrome.** TMJ appliances or similar devices and related services are not

Covered.

15. **Anesthesia.** Services or supplies for the administration of anesthesia for any Surgery or treatment not Covered by the Plan.
16. **Midwife/Doctor Duplicate Services.** Services that are duplicative because they are provided by both a nurse midwife and Doctor.
17. **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical developmental for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, birth defects, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest mental illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law including but not limited to the Handicapped Children Act of 1975 (Public Law 94-142). This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.
18. **Occupational Therapy.** Services or supplies related to occupational therapy that is primarily directed at activities of daily living or occupation. Exceptions: Occupational therapy that is part of an Approved Plan of Care for services by a Home Health Care Agency, Hospice Agency, or Inpatient Care by a Hospital or Skilled Nursing Facility, Convalescent Care Facility, Rehabilitation Facility: or occupational therapy directed at functional body improvement as specifically included under rehabilitation therapy benefits.
19. **Foot Care/Shoes/Orthotics/Supports.** Services or supplies related to routine foot care such as cutting or removal of corns, calluses, nails, routine hygienic care, or preventive Maintenance Care (ordinarily within the realm of self-care). Orthopedic shoes, foot orthotics or other supportive foot devices and for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions or subluxation of the foot despite underlying pathology. Exceptions: Routine foot care ordered by an attending medical Doctor while treating a person with an insulin dependent diabetic condition, removal of nail roots and open cutting corrective procedures.
20. **Weight Reduction/Diet Management /Exercise.** Services or supplies related to weight reduction or diet management for treatment of obesity no matter what age, condition, diagnosis or prognosis of the patient. Diet management, exercise programs or general conditioning programs even when ordered by a Physician.
21. **Inpatient Non-Acute Care/Custodial/Maintenance/Long Term Care.** Services or supplies related to any part of an Inpatient stay that is primarily for physical checkups, diagnostic testing, Custodial Care, Maintenance Care or long term care, residential, sanitarium type, rest cures, or for environmental change or care that cannot reasonably be expected to lessen the patient's disability enabling him or her to leave an institution. Exception: Hospice care services specifically included in the Plan.
22. **Non-Acute Facilities.** Services or supplies rendered in a place of rest, a place for the aged, a nursing home or in an education facility, a place mainly for care of alcoholism, drug addiction, mental disorders or tuberculosis unless the facility meets Plan requirements for Skilled Nursing Facility Coverage, or alcohol/Substance Abuse Facility Coverage and public or Private Psychiatric Facility Coverage for Inpatient mental illness care.

- 23. Skilled Nursing Facility/Medicare.** Services or supplies billed by a Skilled Nursing Facility (SNF) for Inpatient Care when Medicare is the primary plan according to Medicare Secondary Payer rules. The Plan will not pay any Inpatient expenses billed by the SNF including, but not limited to, Medicare deductible, coinsurance and charges Incurred after Medicare exhausted. This applies to the person eligible for Medicare whether or not enrolled.
- 24. Custodial Care or Maintenance Care.** Services or supplies related to care found Custodial or Maintenance Care according to Plan provisions.
- 25. Reversal Sterilization Procedures.** Services or supplies related to the reversal of sterilization procedures, whatever the reason.
- 26. Birth Control.** Services or supplies related to oral contraceptives or birth control devices, whatever the reason.
- 27. Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to start the Pregnancy, prenatal care, delivery or other procedure, and postnatal care. Benefits are available for newborns who meet the child eligibility requirements and are enrolled under family Coverage.
- 28. Gender Identity Disorders.** Services or supplies connected to sex change Surgery or to any treatment of gender identity disorders.
- 29. Cosmetic/Elective Care.** Services or supplies connected with elective care, or cosmetic or beautifying Surgery. Reversal of elective, cosmetic or beautifying Surgery will not be Covered unless found Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Injury or sickness or for reconstructive Surgery that is incidental to or follows Surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive Surgery because of a congenital disease or anomaly of a Dependent child that has resulted in a functional defect.
- 30. Hair Loss/Baldness.** Service or supplies related to hair loss or baldness including, but not limited to, human, or artificial hair transplants, other professional care to stimulate hair growth, drugs to eliminate baldness or stimulate hair growth, wigs and artificial hairpieces. Exception: Limited Coverage specifically included in the Plan for one hairpiece per Lifetime for hair loss resulting from chemotherapy or radiation therapy.
- 31. Smoking Cessation/Tobacco.** Services, supplies, or drugs related to therapy for cessation of smoking or other use of tobacco products even if recommended, ordered or prescribed by a Physician.
- 32. Transportation/Travel.** Services or supplies related to transportation or travel by any means other than an ambulance even if ordered, recommended, or prescribed by a Physician. Services and supplies related to non-emergency ambulance services. Ambulance services when the patient could have been safely transported by other means of transportation. Exception: Ambulance and ambulette Coverage under Home Health Care Agency Coverage.
- 33. Care by Relative/Household Member.** Services rendered by an Immediate Relative or Household Member. Refer to **Section X - Definitions** under *Immediate Relative* and under *Household Member*.
- 34. Free Care.** Services or supplies received for which no charge would have been made without Coverage

under the Plan or for which there is no legal obligation for payment by the Enrollee or Dependent. Exception: Coverage to the extent federal and state law requires the Plan to allow benefits for services otherwise Covered by the Plan.

- 35. Facility Employees.** Separate charges for services by members of the staff employed by a Hospital, Skilled Nursing Facility, Convalescent Care Facility, Rehabilitation Facility, or by any Inpatient facility where care is received.
- 36. Condition Due to Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.
- 37. Illegal Care.** Services or supplies considered illegal according to any governmental laws or regulations.
- 38. Act of War/Riots.** Services or supplies received because of an Injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, or due to participation in a civil insurrection or riot.
- 39. Work-Related/Occupational Conditions.** Services or supplies received because of an occupational Injury or an occupational sickness that entitles the Covered Person to benefits under a worker's compensation, occupational disease law, or similar legislation. Payment will not be made even if you or your Dependent does not claim the entitled benefits.

- 40. Government Programs.** Services or supplies that could be provided by or paid for by any governmental (domestic or foreign) program (other than Medicaid) under which you or your Dependent are or could be covered, including, but not limited to, the Handicapped Children Act of 1975 (Public Law 94-142) Exception: Coverage to the extent that such program requires the Plan to allow benefits that would have been otherwise payable. Medicare as specifically included in **Section V - Medicare Integration with Plan Benefits.**
- 41. Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for Covered Expenses for the following exceptions:
- a. Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.
 - b. State or local government owned Hospital or Skilled Nursing Facility that customarily bills for its services.
 - c. Government owned facility that otherwise meet Plan limitations for Coverage as an Outpatient alcohol or substance abuse treatment facility.
 - d. Government owned facility or public Hospital that otherwise meet Plan limitations for mental Illness care.
 - e. USA military Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their Dependents or for the Dependents of active military personnel.
 - f. Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.
- 42. No-Fault Auto Insurance.** Services or supplies to the extent they are covered under a mandatory motor vehicle liability law that requires benefits be provided for personal Injury without regard to fault. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the automobile insurance denies its benefits as not Medically Necessary, or for late filing. However, expenses not paid under the no-fault insurance due to its deductible and maximum benefit limitations, will be Covered to the extent Allowable Fees would otherwise have been payable under this Plan.
- 43. Third Party Claim Settlement/Action.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or action), other than from an insurance carrier under an individual policy issued to you or your Dependent. Exception: Conditional payments shown in **Section IX - Other Provisions and Procedures** under *Right of Subrogation*. Failure to comply with the conditions of the Plan's right to subrogation could result in denial of benefits.
- 44. Forms/Missed Appointments/Phone Calls/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, or for services or supplies not actually received or provided.
- 45. Other Plan/Benefit Penalties/Primary Care Network/HMO Network.** Services or supplies to the extent such expenses were disallowed by a primary health plan due to failure by their enrollee or participant to follow the requirements of its managed care or benefit management program, pre-admission reviews, second surgical opinion, or any other reason, including failure to obtain services through a health maintenance organization (or similar organization including Medicare Sponsored managed care organization); or failure to abide by the HMO primary Physician network.

- 46. Plan Penalties/Deductibles/Copayments/Benefit Limits.** Services or supplies to the extent they are not reimbursed due to benefit penalties, Deductibles, Copayments or other benefit limits under any portion of this Plan. Exception: When this Plan pays as secondary payer to another Plan according to the coordination of benefits provision.
- 47. Late Claim Filing.** Services or supplies for which an adequate claim is not filed with the Claims Administrator within the Plan time limit for claim submissions. Claims must be submitted no later than 90 days after the end of the Calendar Year in which the Covered Expenses were Incurred. Exceptions may be made at the discretion of the Claims Administrator or the Plan Administrator for late claim filing due to extenuating circumstances beyond the control of the Enrollee.
- 48. Not Included.** Services or supplies that are not included as Covered Expenses under the Plan even if ordered by a Physician. Covered Services or Supplies that are rendered, provided and/or billed by a Provider that is not included for Plan Coverage even if Medically Necessary. This applies even if such services, supplies or Providers are not specifically excluded according to Plan provisions.

SECTION VIII - CLAIM SUBMISSION AND REVIEW PROCEDURES

Each Covered Person or other interested person shall file his or her claims with the Claims Administrator providing pertinent information or written proof that Covered Expenses were Incurred in a manner that the Claims Administrator may require to evaluate the claim for Plan benefits. Failure to furnish such proof as requested will end in denial of benefits or no further benefits, as applicable. The Claims Administrator is responsible for making benefit determinations based on a full and fair review of the information submitted and the provisions of the Plan. Any legal action arising out of the denial in whole, or in part, of Plan benefits shall be directed to the Plan Administrator, the Bedford Central School District.

A. HOW TO SUBMIT A MEDICAL CLAIM

If Medicare or another health plan is the primary plan, claims should first be submitted to those plans and then to POMCO with copies of their explanation of benefits or denial. Claims for conditions due to occupational cause, automobile accident (or automobile related accident) or when benefits could be available under another insurance or similar plan not owned by you or your Dependents should be submitted to the other plan or insurance company. If benefits are denied, bills should be sent to POMCO with a copy of the other coverage denial letter. Be sure to advise the Provider of these situations to avoid overpayment of Plan benefit. *For drug claim submissions, See Section IV - Covered Services under Prescription Drug Expenses*

1. **Network Provider Claims.** A POMCO Network Provider bills POMCO directly for benefits. You or your Eligible Dependent need only present your POMCO identification card to confirm Plan eligibility and complete any information requested by the Provider. Be sure to give the Network Provider full information on other health plans and history of any accidental Injuries.
2. **Hospital Inpatient or Outpatient Claims.** Usually, the Hospital will mail claims directly to POMCO. If you are billed directly, follow the instructions for *Other Claims Submissions* shown below. If you or your Eligible Dependents are covered by more than one plan, the Hospital will usually bill the plans according to standard Medicare or COB order of benefit determination rules. Example: If Medicare is primary, the Hospital will first bill Medicare and then POMCO for any balance. Be sure to provide information concerning all health coverage to help assure proper billing.
3. **Other Claim Submissions.** If Medicare is primary for medical services or supplies, the Provider will usually bill Medicare directly. All you need to do is provide the necessary information to enable the Provider to submit to Medicare. The Provider may then bill you or POMCO directly. If you are billed for Covered Services, you must take the following steps to submit a claim for benefits:
 - a. A District claim form should be obtained from the District or from POMCO.
 - b. Be sure to read the instructions printed on the claim form. **Remember:** You must attach a completed claim form each time you send in medical bills and a separate claim form is needed for each Family Member.
 - c. Once you have completed your portion of the claim form, the Doctor can complete his portion, if needed, or you may attach itemized bills. If an itemized bill is attached, it must clearly state the patient's name, diagnosis, full description of service rendered and an itemized list of charges with dates of service.
 - d. For services rendered by other than a Doctor, the bill should also include the Provider's signature and tax identification number. Any bill from a nurse must show the date, place and hours of duty, charge per hour, total charge per day and signature, credentials and registration number.

- e. If services are due to a non-occupational or other Accidental Injury, you must provide complete details on how, where, the date, and the time such Injury was sustained. If Injury was sustained at a place other than your place of residence, a third party verification form should be obtained from the District Benefits Office or from POMCO and completed by you. Attach completed form with your initial claim to avoid processing delays.
- f. Attach Medicare or other plan explanation of benefits or denial, if appropriate. All completed forms and itemized bills should be submitted to:

**POMCO
P.O. BOX 6329
SYRACUSE, NY 13217-6329**

The Claims Administrator will accept other valid claim forms that provide the necessary information to decide Plan Coverage. If you fail to provide necessary information, your claim could be returned to you to provide missing information or additional details may be requested which could delay the determination of Plan benefits. POMCO will advise you of the approval or rejection of your claim by mail, usually within 30 days following the receipt of satisfactory proof of the claim.

B. TIME LIMIT ON CLAIM SUBMISSION

Written proof of claims should be submitted as expenses are Incurred. However, to be considered for benefits, claims must be submitted (postmarked) no later than 90 days after the end of the Calendar Year in which the Covered Expenses were Incurred. The Plan Administrator or Claims Administrator may also accept a claim after the time limit has elapsed if extenuating circumstances prevented the Enrollee from submitting his or her claim within the time limit.

C. AUTHORIZATION TO PAY PROVIDER/BENEFIT ASSIGNMENT

Although direct payment may be authorized as shown below, under no circumstances may you assign your right to benefits under this Plan to any person, corporation or other organization. You may not assign your right to take legal action under this Plan to any Provider of service. Any assignment of your right to benefits or your right to legal action under this Plan will be void.

Hospital Expense Benefits are generally paid directly to the Hospital or other facility unless the expenses were already paid by your or another plan. Network Provider benefits are paid directly to the Provider. All other health benefits are generally paid directly to you unless you direct payment to the Provider by written authorization. Such an authorization appears on the claim form. A separate claim form should be used for each Provider to whom you want direct payment to be made. The Plan may, at its option, accept such authorization of payment to a Hospital, facility, Physician or other Covered Provider.

In the absence of Provider tax identification information, the Plan may reimburse benefits to you rather than the Provider even if you authorized payment to the Provider. If this Plan is considered secondary payer, the Plan may, at its option, pay you, the Provider, or pay the primary plan for its overpaid benefits. If you die, the Plan may elect to pay benefits to any unpaid Provider, your estate, your Spouse, your parents, your children or your brothers and sisters, as deemed appropriate.

D. HEALTH CLAIM INQUIRIES

When you have any questions concerning Your Coverage, you may call the District Benefits Office or call POMCO at their toll-free number, 1-800-695-5170.

E. CLAIM APPEALS PROCEDURES

- 1. Denial by Claims Administrator.** If a Covered Person's claim for benefits under this Plan is denied, in whole or in part, the Claims Administrator will provide written notice of the denial usually within 30 days after receipt of satisfactory proof of claim. If special circumstances require an extension of time for processing the initial claim, a written notice of the extension and the reason will be furnished to the claimant before the end of the initial 30-day period. In no event will such extensions exceed an additional 90 days. Commencement of benefits payment will establish notice of approval of a claim to the extent of the amount of the approved benefit. For all purposes of the Plan, such decision on claims (unless claim appeal review requested) shall be final, binding and conclusive on all interested parties as to participation concerning the Plan. The notice denying a claim for benefits will be written and will include:

 - a. The specific reasons for the denial;
 - b. Specific references to the pertinent Plan provisions on which the denial is based;
 - c. A description of additional information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and,
 - d. Information about how to submit the claim for review.

- 2. Initial Appeal of Claim Denial.** If a claim for benefits is denied or if the applicant had no response to such claim within 30 days of its submission (in which case the claim for benefits will be deemed to have been denied), the applicant may appeal the denial to the Claims Administrator within 60 days from the date of the receipt of written notice of the denial or 60 days from the date such claim is deemed to be denied. The request for appeal must be in writing and sent to POMCO, Claims Review, P.O. Box 6329, Syracuse, NY 13217-6329. In pursuing such appeal, the applicant or his or her duly authorized representative:

 - a. May request in writing that the Plan Administrator or the Claims Administrator review the denial;
 - b. May review pertinent documents; and,
 - c. May submit issues and comments in writing, stating the reason or reasons for the disagreement with the claims determination in clear and concise terms.

Following receipt of the written request for review and any supporting information submitted with the request, the Plan Administrator or Claims Administrator will fully and fairly review the previous claim determination. The decision on review shall be made by the Plan Administrator or the Claims Administrator within 60 days of receipt of the request for review, unless special circumstances require an extension of time for independent investigation concerning the merits of the denied claim, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. If such extension of time is required, written notice of the extension shall be furnished to the claimant before the end of the original 60-day period. The decision on review shall be made in writing, and shall include specific references to the provisions of the Plan on which the denial is based. If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review and the claimant shall be allowed to exercise the right to pursue any other legal or equitable remedy otherwise available. If the participant continues to disagree with the appeal review, then he or she may request a final review as shown below. For all purposes under the Plan, the decision on the appeal review (unless final appeal review requested) shall be final, binding and conclusive on all interested parties as to participation relating to the

Plan.

- 3. Final Appeal Review.** If an Enrollee or Covered Person is not satisfied with the decision made on his or her initial appeal, a final appeal may be made directly to the Bedford Claims Appeal Committee (Committee). This Committee is composed of two appointees of the Superintendent of Schools and, according to which unit the appeal or complaint is in, either the president of the Civil Service Employees Association and one appointee of the President of the Civil Service Employees Association; or the President of the Bedford Teacher’s Association and one appointee of the Bedford Teacher’s Association; the President of the Bedford Association of School Administrators and one appointee of the Bedford Association of School Administrators.

The final appeal must be in writing and sent to the Plan Administrator within 30 days after receipt of the full or partial denial of benefits based on the initial claim appeal decision. The Committee may, in its sole discretion, accept the appeal after such time has elapsed if, in their opinion, extenuating circumstances prevented the participant from making a claim during such period. If necessary, the Plan Administrator will delete or redact the Employee, retiree and/or Dependent’s name before they refer the appeal documents to the Committee. Throughout the claims appeal process, confidentiality will be maintained. The Committee will complete its review of the claim appeal within 20 days after its receipt of the appeal documents. The determination of the Committee will be final and binding on all parties, unless the Committee fails to reach a majority decision.

If the Committee cannot reach a majority decision, the matter may be submitted for binding arbitration within 10 days of receipt of the Committee decision. This arbitration is to be presented before a Physician arbitrator chosen through the American Arbitration Association. The costs of any arbitration procedures will be shared by the District and according to which unit the appeal or complaint is in, either the Civil Service Employees Association; Bedford Teacher’s Association; or the Bedford Association of School Administrators. The determination of the arbitrator on the matter in review shall be issued within 30 days of the hearing before the arbitrator and will be final and binding on all concerned parties. The arbitrator cannot add to, modify or deviate from the terms of the health Plan.

F. LEGAL PROCEEDINGS

No action at law or equity shall be brought to recover under the Plan before the expiration of the later of 60 days after proof of claim has been furnished to the Claims Administrator or 30 days after the exhaustion of all appeal rights under this section of the Plan, nor shall any such action be brought at all unless commenced within two years from the date the Covered Services or Supplies were Incurred. However, in the event this self-funded Plan is being canceled and the Covered Person is notified of the cancellation, no action to recover under this Plan shall be brought unless commenced before the later of 30 days after the date of such notification or 90 days from the date of the Plan cancellation. The agent for service of legal process is the Bedford Central School District.

SECTION IX – OTHER PROCEDURES AND PROVISIONS

A. NOT A CONTRACT

Any and all rights accruing to any person under the Plan shall be subject to the terms and conditions of the Plan. The Plan shall not constitute a contract between the Plan Sponsor and any Covered Enrollee or participant, nor shall it be considered an inducement for the initial or continued employment of any Employee. Likewise, maintenance of the Plan shall not be construed to give any Employee the right to be retained as an Employee by the Plan Sponsor or to any benefits not specifically provided by the Plan.

B. VERIFICATION OF CLAIM INFORMATION

The Plan Administrator and the Claims Administrator have the right to request from you or your Eligible Dependents, Hospitals, approved facilities, doctors or other Providers any medical records or other information that is necessary for the proper handling of claims. When you become Covered under the Plan, you automatically give permission to the Plan Administrator and the Claims Administrator to obtain and use those records and that information. Failure to release such information on a timely basis, or failure on the part of the Enrollee, patient, parent or guardian to authorize the release of appropriate information could result in denial of benefits. The Claims Administrator confidentially maintains all medical records.

C. RIGHT OF EXAMINATION

The Plan Administrator shall have the right, to require an independent medical examination for you or your Eligible Dependent when and so often as it may reasonably require such examination during the determination of a claim.

D. INDEMNITY BENEFITS

Benefits under the Plan are only available for services rendered. Except as otherwise specified, benefits cannot be preapproved. Benefit determination will be based on Plan limitations (eligibility, benefits, etc.) and exclusions in effect at the time service is rendered.

E. MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your Dependent or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

F. REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for Covered Services or Supplies under the Plan that is more than the benefit that should have been paid or for services or supplies which should not have been paid according to Plan provisions, the Plan Administrator shall have the right to demand a full refund or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits available to such Covered Person or other present or future amounts available to such person, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall determine. Each Covered Person hereby authorizes the deduction of such excess payment from such benefits or other present or future compensation payment. Payments made in error for services or supplies not Covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for all claims submitted under the Plan.

G. RIGHT OF REIMBURSEMENT

This Plan specifically does not provide any Coverage with respect to any Injury or Illness for which a third party may be liable or legally responsible. If you or your Dependent receives payment or expects payment from a third party insurance, surety or other type plan not owned by or issued to you or your Dependent for medical expenses resulting from such Injury or Illness, you should not submit a claim under this Plan for such medical expenses. Any Plan benefits paid against such claims will be considered an overpayment. The Plan will

exercise its right to full reimbursement for resulting overpayments. However, if for some reason the third party claim payment or settlement is expected to be delayed for an extended time, the Plan Administrator may, at its option, authorize Plan benefits for medical expenses that would otherwise be Covered by this Plan. The rules shown below govern how this Plan pays benefits in such situations.

- 1. Conditional Benefit Payment.** If a Covered Person has medical expenses resulting from an Injury, accident or Illness for which a third party is, or may be, held responsible and such third party payment or settlement is withheld for an extended period, the Plan Administrator may, at its option, authorize conditional interim benefit payments for medical expenses that would otherwise be Covered by the Plan. However, any advance payments are subject to the Plan's reimbursement rights. Before such benefits are conditionally made, you and/or your Eligible Dependent, or authorized representative, if a minor, must execute an agreement that acknowledges and affirms (a) the conditional nature of such benefit payments and (b) the Plan's rights of reimbursement for benefits paid, as shown below.

- 2. Reimbursement Agreement.** If benefits are paid or available as the result of an action of a third party, this Plan will be entitled to full recovery of its payments on behalf of any Covered Person with respect to such action. In addition, once it is determined that a third party is liable in any way for the Injuries or Illness giving rise to these expenses, to receive benefits, or to continue receiving benefits from this Plan, you must take the following steps or all benefit payments to you will be stopped.

You are required to advise this Plan in writing of any expenses for which a third party may be liable. You and/or your Eligible Dependent or authorized representative, if a minor or if unable to sign, must execute and deliver such documents, notices or papers as may be required and must do whatever else is needed to secure the Plan rights, including the following:

- a. You and/or your Eligible Dependent or legal representative must agree, in writing, to provide the Claims Administrator with written notice whenever a claim is asserted or could be asserted against and/or recovery is received from any third party (or insurer or surety thereof) for damages as the result of the Injury or Illness; and
- b. You and/or your Eligible Dependent or legal representative must agree, in writing, on a form acceptable to the Claims Administrator, to reimburse this Plan for any benefits paid by this Plan due to such Injury or Illness. Such Plan benefits must be reimbursed 100% from any settlement, judgement or other payment that you obtain from the liable third party before they take out any other expenses, including attorneys' fees, from the payment. The amounts to be recovered by the Plan pursuant to this provision cannot be reduced by any attorney's fees, court costs or other disbursements.
- c. You and/or your Eligible Dependent or legal representative must provide, in writing, an assignment of proceeds or a lien against such proceeds, in favor of the Plan in the amount of any benefits paid by the Plan due to such Injury or Illness; such assignment to be valid against any judgement, settlement, or recovery in any manner that is or will be received from such third party or third party's insurer or surety.

If you or your Dependent fails to tell this Plan that you or your Dependent has a claim against a third party; if you or your Dependent fails to assign your claim against the third party to the Plan when required to do so (and to cooperate with this Plan's subsequent recovery efforts); if you or your Dependent fails to require any attorney subsequently retained to sign the Plan's lien forms; if you and/or your Dependent and/or authorized representative or attorney fail to fully reimburse this Plan out of any payment obtained from the third party or fail to fully reimburse the Plan, then you are personally liable to this Plan for the reimbursement owed this Plan as the result of the third party payment or settlement. This Plan may then request reimbursement from you and offset the amount you owe from any future benefit claims for any

Covered Family Member or if necessary and/or take legal action against you.

The Plan reserves the right to deny benefits for any charges that are or could be considered subject to the Plan's right of reimbursement in the case of failure by you and/or your Eligible Dependent or legal representative to comply with the above conditions. The conditions shown above will not apply to benefits paid under Medicare supplementary coverage nor to any payments made under any insurance policy, plan or certificate issued to you or your Eligible Dependents.

H. AMENDMENTS OR CANCELLATION OF THE PLAN/ RIGHT TO DEVELOP GUIDELINES

The Plan Administrator, in its sole discretion, reserves the right to amend, reduce, revise or cancel any or all of the benefits, limitations, provisions, inclusions or exclusions of the Plan. If the Plan cancels, Coverage will end for all persons enrolled under the Plan. The Plan Administrator reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures for which expenses for services and supplies may be approved within the limitations and exclusions of this health Plan.

I. CONFORMITY WITH LAW

This Plan will be governed and construed according to any federal or state laws to which it is subject. If any provisions of the Plan are contrary to any law to which it is subject, then such provision will be automatically amended to conform or comply with such law. If the Plan does not include provisions to comply with any law for which it is subject, then the Plan will automatically be amended to include such provisions.

J. SEVERABILITY

If any provision of the Plan shall be found by a court of competent jurisdiction to be void, invalid or unenforceable, the same shall either be reformed to comply with applicable law or stricken if not so conformable, so as not to affect the validity or enforceability of the remainder of the Plan.

K. WAIVER AND ESTOPPEL

No term, condition, or provision of this Plan shall be deemed waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only regarding the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than specifically waived. No participant other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

HEADINGS

All article and section headings in the Plan have been inserted for convenience only and shall not decide the meaning of the content thereof.

SECTION X – DEFINITIONS

Certain words and phrases applicable to or used in this SPD are listed below with the definition or explanation of the manner in which the term is used for the purpose of the Plan. Masculine pronouns used in this SPD shall include masculine or feminine gender, unless the context indicates otherwise.

ACCIDENTAL INJURY – Non-occupational bodily Injury caused by an event that is sudden and not foreseen, and is exact as to time and place. Injury must be unexpected and unavoidable. The breakdown or fracture of natural teeth or other dental condition caused by chewing will not be considered an Accidental Injury.

ACTIVELY EMPLOYED/ACTIVE EMPLOYMENT - An Employee who is on the regular payroll of the District and does, for the most part, all the substantial and material duties of the job and regularly works the minimum hours per day or week established by the Employer for eligible employment or who is on an approved paid Leave of Absence.

ALCOHOL ABUSE FACILITY - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the treatment of alcoholism. For services rendered outside New York State, the Alcohol Abuse Facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Health Care Organizations for the treatment of alcoholism.

ALLOWABLE FEES - The Usual, Customary and Reasonable Charges as determined by the Claims Administrator for Covered medical services rendered and billed by Covered Out-of-Network Providers. If billed by Network Providers, Allowable Fees means the network scheduled allowance or negotiated discount based on the Provider's or network agreement with the Claims Administrator. The Plan will not pay charges that exceed Allowable Fees. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

ALLOWABLE SERVICES OR SUPPLIES - See Covered Services or Supplies.

AMBULATORY SURGERY - Surgery given on other than an Inpatient basis. For example in a Physician's office, a clinic, Outpatient department of a Hospital, ambulatory facility or other Outpatient location.

AMBULATORY SURGICAL FACILITY - A specialized facility operated, according to the applicable laws of the jurisdiction in which it is located; or accredited by the Joint Commission for the Accreditation of Health Care Organizations or the Accreditation Association for Ambulatory Care; or approved by Medicare, to render Outpatient services for Ambulatory Surgery. The facility must be organized and used mainly for Outpatient Surgery, have a staff of surgeons and anesthesiologists, and full-time professional nurses. An Ambulatory Surgery center that is part of a Hospital is not considered an Ambulatory Surgical Facility.

AMENDMENT - A change, revision, deletion or addition to the Plan Description or document by the Plan Administrator.

APPROVED CARE OR PLAN OF CARE - Any service or course of treatment approved for benefits by the Claims Administrator under the terms and limitations of the Plan.

AVERAGE SEMI-PRIVATE ROOM RATE - The standard semi-private rate in the Hospital or facility. If the Hospital does not have a semi-private rate, the semi-private rate shall be deemed to be 80% of the room and board charges made by the Hospital or facility for its lowest priced private room accommodations. If the Hospital has several semi-private rates, the prevailing, or the most common rate, shall be used. Semi-private

accommodations are usually rooms with two or more beds.

BIRTH CENTER OR BIRTHING CENTER - A free-standing facility or a Hospital center that is established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located, or accredited by either the Joint Commission for Accreditation of Health Care Organizations or the Accreditation Association for Ambulatory Care; or by Medicare, to provide Inpatient and Outpatient maternity care for uncomplicated pregnancies, including routine prenatal care, routine full-term delivery, and immediate postpartum care. The facility must have an agreement with a local Hospital to accept emergency admissions of its maternity patients with serious complications.

CALENDAR YEAR - A period of twelve months, commencing with January 1 and ending December 31 of the same year.

CALENDAR YEAR DEDUCTIBLE - The amount of allowable expenses that must be paid by the Employee each Calendar Year before the Claims Administrator can determine benefits. See also Deductible.

CLAIMS ADMINISTRATOR - The person or organization under contract with the Plan for the processing and determination of benefits under the Plan.

COBRA - The continuation of Plan Coverage according to Federal regulations under the Consolidated Omnibus Budget Reconciliation Act of 1986 and subsequent Federal COBRA regulations affecting this type of Plan.

COLLEGE OR UNIVERSITY - An institution accredited in the current American Council on Education publication of Accredited Institutions of Post-Secondary Education.

CONTRIBUTION - The portion of the Plan costs that the Plan Administrator or Plan Sponsor collects from Plan participants.

CONVALESCENT CARE FACILITY - See Skilled Nursing Facility.

COPAYMENT - That figure shown as a Percentage used to compute the amount of benefits available or a dollar amount applied to Allowable Fees. The Covered Person is responsible for payment of the Copayment reduction amount.

1. Percentage Copayment is the Percentage of Allowable Fees, after applicable Deductible, that the Plan pays for Covered Services or Supplies under Major Medical Expense Benefits. The Enrollee is responsible for payment of the balance.
2. Network Copayment is the portion of Network Allowable Fees that the Employee must pay to the Network Provider. The balance is paid by the Plan.
3. Drug Copayment is the dollar amount that the Employee must pay toward the cost of a generic or brand name drug purchase. This Copayment is separate from any other Plan Copayments. The balance of Allowable Fees is paid by the Plan.

COVERAGE OR COVERED - Health services or supplies for which benefits are available under the Plan.

COVERED EXPENSES - See Allowable Fees.

COVERED PERSON - Any person enrolled and eligible for benefits or Coverage under this Plan.

COVERED PROVIDER - See Provider.

COVERED SERVICES OR SUPPLIES - Services or supplies included for Plan Coverage and found Medically Necessary according to Plan provisions.

CUSTODIAL CARE - Any institutional, Outpatient or professional care which is not for diagnosis or treatment. Care is also Custodial when it is primarily to meet personal needs. Examples of Custodial Care are: Assistance in the activities of daily living (such as help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine); administration of oral medications; assistance with supportive or Maintenance Care physical therapy; care due to incontinence; turning and/or positioning in bed; acting as a companion or sitter; or nurse aide services.

DEDUCTIBLE - The amount of allowable expenses that must be paid by the Employee before certain benefits can be determined by the Claims Administrator. See also Calendar Year Deductible.

DEPENDENT - An Enrollee's legal Spouse or an Enrollee's child who meets the conditions shown in Section II - Eligibility and Enrollment.

DOCTOR - For the purposes of the Plan means a person legally licensed to practice medicine (MD) or osteopathy (DO). See also Physician.

DURABLE MEDICAL EQUIPMENT - Equipment found Medically Necessary according to Plan provisions for the treatment of disease or Accidental Injury or to improve body function lost as the result of a disease, Injury or congenital abnormality which meets all of the following requirements. Durable Medical Equipment must be:

1. Prescribed by a Physician who indicates the necessity of the item, including diagnosis, reason for use, purpose, expected duration of use and a full description of item prescribed;
2. Non-aesthetic in nature;
3. Safe and effective for home use without medical supervision;
4. The most appropriate equipment or model for the reported condition. Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition;
5. Made to stand extended and repeated use. Disposable supplies may be allowed if required to operate the medical equipment;
6. Required to replace body function lost or impaired due to disease, Injury or congenital abnormality or is Medically Necessary to carry out necessary activities of daily living connected to the patient's health or hygiene with little to no aid from others. It must not be solely for the convenience of the patient or the patient's caregiver;
7. Used to serve a medical purpose. It must not be useful without disease or Injury and must not be for comfort, used to enhance the patient's home or environment, alter air quality or temperature or for exercise or training.

EFFECTIVE DATE OF COVERAGE - The date Coverage is effective with respect to an enrolled and eligible Employee or Dependent.

ELIGIBLE DEPENDENTS - See Dependents.

EMPLOYEE - Any person who is considered an Employee of the District according to the eligibility requirements of the Plan. Former Employees or retirees may also be designated Employees if so designated by the District eligibility requirements.

ENROLLEE or Covered Enrollee - An enrolled and eligible Employee, retiree, surviving Dependent or COBRA participant under whose social security number enrollment is made.

EXPERIMENTAL - See Investigative.

EXTENDED CARE FACILITY - See Skilled Nursing Facility.

FAMILY MEMBERS - The Enrollee and his or her eligible Dependents enrolled in the Enrollee's family Coverage.

FULL-TIME - A basis of employment which requires the Enrollee to be at work for at least the qualifying hours per week based on criteria established by the District or by negotiated bargaining agreements with the District.

GENERAL ANESTHESIA - The administration of anesthesia consisting of spinal or rectal anesthesia or by a drug or other agent administered by injection or inhalation, other than local infiltration, the purpose of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

GENERAL HOSPITAL - See Hospital.

GENERIC DRUG - A drug, available only upon the written prescription of a Physician, used for the treatment of an Illness or Injury and supplied in its generic or chemical name rather than as a proprietary, trade or brand name product.

HANDICAPPED CHILDREN ACT OF 1975 (Public Law 94-142) - The federal Handicapped Children Act of 1975 (Public Law 94-142), as amended, assures that all handicapped children have free appropriate public education through their local public school system. This public education emphasizes special education and related services to meet their needs. It requires the local public school systems to provide the opportunity for due process evaluations and impartial hearings by the parents or guardians of such children. The term handicapped child includes, but is not limited to, a child who mentally retarded, hard of hearing deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or specific learning disabilities and because of one or more of these impairments need special education and related services. The public school system is responsible for providing or paying the cost of any developmental, corrective or supportive services as mandated by the Public Law 94-142. Complete information concerning benefits available and procedures for this special education and supportive services can be obtained from the administrative office of your local public school system.

HEALTH CARE BENEFITS - Hospital-medical-surgical benefits.

HOME HEALTH CARE AGENCY - An agency that meets all of the following criteria:

1. It must be duly accredited to provide skilled services and other therapeutic services according to state regulations; and
2. In New York State, it must be certified and have a valid license under Article 36 of the New York State Public Health Law. If outside New York State, it must have an appropriate operating certificate issued by the appropriate state agency in the state where the care is rendered. The Provider outside New York State must be a Hospital or a nonprofit or public home health service or agency.

HOME HEALTH AIDE - A person, other than a Physician or a nurse, who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE PLAN - A plan to provide out of Hospital care to a person rendered by an approved Home Health Care Agency. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Convalescent Care Facility/Extended Care Facility/Skilled Nursing Facility if he did not have the care and treatment stated in the care plan.

HOSPICE AGENCY - An organization that has an appropriate operating certificate issued by the New York State Department of Health to provide hospice care. Outside New York State, the Hospice Agency must be certified under criteria similar to those used in New York by a state agency in the state where the hospice care is provided; or Medicare must approve it for hospice care.

HOSPICE CARE PLAN - A Plan of Care for treatment of a terminal patient that is established and conducted by the Hospice Agency under the supervision of a Physician.

HOSPICE UNIT - A Hospice facility or a separate Hospital unit that provides treatment under a Hospice Care Plan and admits patients who are not expected to live more than six months due to terminal illness.

HOSPITAL - An acute care institution that makes charges and is engaged primarily in providing medical care and treatment to sick and injured persons on an Inpatient basis at the patient's expense, which fully meets all of the following requirements:

1. It is an institution operating and licensed according to the law of the jurisdiction in which it is located concerning institutions identified as Hospitals;
2. It is primarily engaged in providing diagnosis, treatment and care of injured or sick persons on an Inpatient basis and receives compensation from its patients. It maintains facilities on the premises for major operative Surgery, and it provides twenty-four (24) hour nursing care by professional registered nurses;
3. It is not a Skilled Nursing Facility and is not, other than incidentally a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of drug addiction or alcoholism; and
4. It is a Hospital accredited by the Joint Commission on Accreditation of Health Care Organizations or certified by Medicare as an acute care facility.

The term Hospital shall also include a Medicare approved free standing kidney dialysis facility for kidney dialysis services and a public (government owned) mental health facility for Inpatient or Outpatient care of mental illness.

HOSPITAL MISCELLANEOUS EXPENSES - Charges made by a Hospital on its own behalf for medical services or supplies given to a Covered Person either on an Inpatient or Outpatient basis. Such services or supplies must be Medically Necessary for the patient's treatment. Room and board and professional services (including intensive nursing care by whatever name called), are not considered Hospital Miscellaneous Expenses whether given under the direction of the Hospital or otherwise.

HOUSEHOLD MEMBER - Any person sharing a common abode as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

ILLNESS - Any non-occupational Injury, sickness or disease that manifests treatable symptoms and requires treatment of the affected Covered Person.

IMMEDIATE RELATIVE of patient or Enrollee means any of the following:

1. Spouse of the patient or Enrollee;
2. Natural or adoptive parent, child or sibling;
3. Stepparent, stepchild, stepbrother or stepsister;
4. Father-in-law, mother-in-law, brother-in-law, or sister-in-law;
5. Grandparent or grandchild; or
6. Spouse of grandparent or grandchild.

INCURRED OR INCURRED DATE - The date the actual service or supply was rendered or received.

INCURRED EXPENSES - Those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

INJURY - A non-occupational accidental bodily Injury of a Covered Person which was caused by an external force and is unrelated either directly or indirectly to all other causes. Any condition or Illness that is caused by or contributed to by a hernia of any kind will be considered a sickness.

INPATIENT OR INPATIENT CARE - The period during which you are treated at a Hospital or a Convalescent Care Facility/Extended Care Facility/Skilled Nursing Facility or other facility as a registered bed patient for whom room and board charges are made.

INSURERS - An insurance or reinsurance company and excess or stop loss carriers.

INVESTIGATIVE OR EXPERIMENTAL - Any care that is not widely accepted professionally in the United States as effective, appropriate and essential treatment of a reported Illness or Injury based upon recognized standards of health care. A drug, device, medical treatment or procedure is Investigative or Experimental if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished or an FDA approved drug or device is used for purposes other than those conditions for which approved; or
2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to decide its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
3. Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
4. Reliable evidence shows that the consensus among experts is that the drug, device or medical treatment or procedure once recognized as effective is no longer considered usual, customary, reasonable or necessary care;
5. The Federal Health Care Finance Administration (HCFA) Coverage criteria are not met for the drug, device or medical treatment or procedure; or
6. The Plan Administrator, in its sole discretion, decides that the treatment, procedure, device, drug or medicine is Investigative or Experimental.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treatment facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure. If any of the entities used to determine the Investigative nature of a drug, device,

supply, treatment or any other medical service, reverses, modifies, or establishes its policy or protocol for such expenses and makes such changes retroactive, the Plan will not make payment for retroactive Incurred Expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

LEAVE OF ABSENCE - A period during which an Employee is not actively working, whether or not receiving compensation or wages, is eligible to continue under the Plan with specific advance written approval of the District based on established criteria or based on the Family Medical Leave Act, a federal law.

LIFETIME - Any reference to Lifetime shown in this Plan means all periods during which the person is Covered under the Plan. Under no circumstances, does the Plan pay benefits for any period during which the person does not meet Plan eligibility or continuation requirements.

MAINTENANCE CARE - Care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

MEDICAL BENEFITS - Plan payment for Covered medical services, supplies or devices related to treatment of Illness or Injuries and for specified preventive services.

MEDICALLY NECESSARY OR MEDICAL NECESSITY for purposes of benefit determination means services, drugs, supplies or equipment provided to a patient for the treatment of an Illness or Injury, only when it meets all of the following requirements:

1. It is consistent with the symptom or diagnosis and treatment of the sickness, disease, ailment or Injury;
2. It is according to generally accepted standards of good medical practice in the USA;
3. It is not primarily for the convenience or personal comfort of the Covered Person, Physician, other caregiver or Household Member;
4. It is the most appropriate level of service, drugs, supplies or equipment that can be safely provided to the Covered Person;
5. It is not Experimental or Investigative and not of an educational nature or provided primarily for medical or other research;
6. It is not considered Maintenance Care or Custodial Care; and
7. It is care requiring the credentials and technical skills of the Provider of service.

The Plan Administrator reserves the right to decide in its discretion, if a service or supply is Medically Necessary. The determination will consider but not be limited to, the findings and assessment of the following entities:

1. The Office of Medical Application of Research of the National Institutes of Health, the Office of Technology Assessment of the United States Congress, the Federal Health Care Finance Administration (HCFA), or any similar entities;
2. The National Medical Associations, Societies and Organizations;
3. The FDA; or
4. The Plan Administrator's own medical and legal consultants and advisors.

The fact that a Physician or other health care professional may prescribe, recommend, order or approve a service or supply **does not, by itself**, decide Medical Necessity or make such service or supply eligible for benefits, even if not expressly excluded under the Plan. If any of the entities used to determine the Medical Necessity of a drug, device, supply, treatment or any other medical service, reverses, modifies, or establishes its policy or protocol for such expenses and makes such changes retroactive, the Plan will not make payment for

retroactive Incurred Expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

MEDICARE - The Coverage of health care costs provided under the provisions of the Federal Social Security Act (42 USC 1395 et seq.) as it is now and may be amended.

MENTAL HEALTH CARE - Treatment for a diagnosed mental disease or disorder or a functional nervous disorder, as described in the most current edition of American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. See also Illness.

MENTAL ILLNESS - See Mental Health Care.

MISCELLANEOUS HOSPITAL EXPENSES - See Hospital Miscellaneous Expenses.

NETWORK PROVIDER - An organization, Physician, Hospital, Pharmacy or other professional healthcare Provider that, at the time Covered Services or Supplies are provided, is part of the participating network (s) selected by the plan. The Network Provider has a contract or agreement with the Network organization and the Claim Administrators to bill negotiated charges or allowances for Covered Services or Supplies when Incurred by Covered Persons.

NON-OCCUPATIONAL ILLNESS, DISEASE OR INJURY - An Illness, disease or Injury that does not arise and is not caused or contributed to, by or because of, any disease or Injury that arises out of or during any employment or occupation for compensation or profit.

NONPARTICIPATING PHARMACY - A Pharmacy that, at the time Covered Services or Supplies are provided, does not have a contract or agreement with the Claim Administrator selected by the Plan Administrator to provide administer drug claim benefit to the Covered Persons under the Plan for scheduled or negotiated charges or allowances.

NONPARTICIPATING PROVIDER - See Out-of-Network Provider.

OUT- OF - NETWORK PROVIDER - An organization, Physician, Hospital, Pharmacy or other healthcare Provider that, at the time Covered Services or Supplies are provided, does not have a contract or agreement with the Claim Administrator or the Participating Provider network selected by the Plan Administrator to provide medical services or supplies to the Covered Persons under the Plan for scheduled or negotiated charges or allowances.

OUTPATIENT - Care rendered in the Outpatient or emergency department of a Hospital or other health facility or care rendered in the Provider's office, patient's home or other care rendered on other than an Inpatient basis.

PARTICIPATING PROVIDER - See Network Provider.

PERCENTAGE COPAYMENT - See Copayment.

PARTICIPATING PHARMACY - See Network Provider.

PHARMACY - An establishment operating under and within the jurisdiction of state laws concerning Pharmacies to dispense prescriptions and where the prescription drugs are dispensed by a licensed pharmacist within the jurisdiction of the license.

PHYSICIAN - Medical doctors, osteopaths, podiatrists, chiropractors and certified nurse midwives, who are legally licensed and performing services within the scope of and jurisdiction of their license; licensed psychologists, for the treatment of mental illness rendering a Covered service within the scope of and jurisdiction of their certification and license; licensed dentists rendering a Covered service within the scope and jurisdiction of their license.

PLAN OF CARE - See Approved Care.

PREADMISSION TESTING - Diagnostic tests rendered on an Outpatient basis before scheduled Hospitalization for Inpatient Surgery. Such tests must be done within fourteen (14) calendar days before admission by the admitting Hospital doing the Surgery. Tests must be related to the Surgery, require the physical presence of the patient and must be recent enough to be useful upon admission.

PREGNANCY - That physical state that results in childbirth, abortion or miscarriage. This definition includes medical complications of the physical state of Pregnancy. For the purposes of the Plan, Pregnancy will be considered the same as any other Illness.

PRIVATE PSYCHIATRIC FACILITY - See Psychiatric Facility.

PROSTHETICS - The making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include eye examinations, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

PROVIDER - Any legally licensed Doctor, osteopath, dentist rendering a Covered service within the scope and jurisdiction of their license, including their charges for services by their employed health care professionals who are licensed and rendering a Covered service within the scope and jurisdiction of their license); legally licensed podiatrist, chiropractor, registered professional nurse, certified nurse midwife, optometrist, physical therapist, speech therapist, podiatrist, chiropractor, clinical psychologist, rendering a Covered service within the scope and jurisdiction of their license; any licensed independent laboratory or other Covered facility/agency legally licensed and rendering a Covered service within the scope and jurisdiction of the license.

PSYCHIATRIC FACILITY: A private facility that has been approved by the Joint Commission on Accreditation of Health Care Organizations as an Inpatient facility for the treatment of mental illness and is licensed by appropriate state agencies. A public (government owned) mental health facility for the treatment of mental illness.

PSYCHIATRIC CARE - See Mental Health Care

REHABILITATION FACILITY/SKILLED NURSING FACILITY - See Skilled Nursing Facility.

ROUTINE NEWBORN NURSERY CARE - Charges made by the caring Hospital or a similar institution and the attending Physician for Custodial and nursing care, including circumcision, of a newborn infant deemed to be free of any identifiable illness or disease requiring treatment.

SEMI-PRIVATE ROOM CHARGE - See Average Semi-Private Room Rate.

SICKNESS - See Illness.

SKILLED NURSING FACILITY/REHABILITATION FACILITY - An institution or part thereof that meets one of the following requirements:

1. The facility or part thereof must be licensed and operating within the jurisdiction of applicable state laws, if any, and accredited as a Skilled Nursing Facility, by the Joint Commission on Accreditation of Health Care Organizations; or
2. The facility or part of the facility (including a facility referring to itself as an Extended Care Facility, Rehabilitation Facility or Convalescent Care Facility or any other similar nomenclature) must be certified by Medicare as a participating facility eligible for Medicare Part A Inpatient Skilled Nursing Facility benefits.

SPEECH FUNCTION - The ability to express thoughts, speak words and form sentences appropriate to the patient's age.

SPELL OF ACCIDENTAL INJURY - A period beginning with the first allowable care for treatment of an Injury or Injuries as an Inpatient in a Hospital, Skilled Nursing Facility or other facility or for Home Health Care Agency services in lieu of Inpatient Care and ending when, for period of at least 90 days, the patient has not been confined as an Inpatient in a Hospital, Skilled Nursing Facility or other facility or has not received Home Health Care Agency services in lieu of Inpatient Care. A Spell of Accidental Injury applies to all Injuries caused by the same accident. A separate Spell of Accidental Injury will apply to each accident.

SPELL OF ILLNESS - A period beginning with the first allowable care for treatment of any Illness or Injury as an Inpatient in a Hospital, Skilled Nursing Facility or Birth Center or for Covered Home Health Care Agency services in lieu of Inpatient Care and ending when, for a period of at least 90 consecutive days, the patient has not been confined as an Inpatient in a Hospital, Skilled Nursing Facility or Birth Center or has not received Home Health Care Agency services in lieu of Inpatient Care.

SPOUSE - The legal wife or husband of the eligible Employee or retiree.

SUBSTANCE ABUSE FACILITY - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the treatment of substance abuse. For services rendered outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Health Care Organizations for the treatment of substance abuse. For the purpose of the Plan, the term "substance abuse" does not include alcohol abuse.

SURGERY - Any of the following:

1. To incise, excise or electrocauterize any organ or body part, except for dental services;
2. To repair, revise or reconstruct any organ or body part;
3. To treat or to reduce by manipulation a fracture or dislocation;
4. Using endoscopy to diagnose or explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. An injection for contrast media testing.
6. Other procedures may be considered as Surgery if deemed such by the Claims Administrator.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES - The **lowest of:**

1. The actual charge for the service or supply; or
2. The usual charge by the Doctor or other Provider for the same or similar service or supply; or
3. The usual charge of other doctors or other Providers in the same or similar geographic area for the same or similar service or supply (prevailing fee).

In the determination of benefits for a claim, the usual level of charges may be modified by a relative value study,

where appropriate, to model actual claims experience in a given area across a range of percentiles. The term "area" as it would apply to any particular service, medicine, or supply means a zip code, county or such greater area as is necessary to obtain a representative cross section of level charges. The part of the cost that exceeds that of any other services that would have been sufficient to safely and adequately diagnose or treat an individual's physical or mental condition will not be deemed as UCR charges. The Claims Administrator makes the determination of the UCR Charge for a Covered service or supply based on the above rules.

WAITING PERIOD - The period of time between the Employee's date of eligibility and/or hire and the date the Employee becomes Covered under the Plan.