MASTER PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

JEFFERSON-LEWIS ET. AL. SCHOOL EMPLOYEES' HEALTHCARE PLAN

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the Superintendent of Insurance. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability.

The contents of this SPD, which describes the Plan provisions, are subject to approval by the New York State Department of Insurance. The benefits, terms and conditions could change without notice pending its review.

Plan Restatement Date July 1, 2011

TABLE OF CONTENTS

INTRODUCTION ... 1
ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS ... 4
ELIGIBILITY ... 4
FUNDING ... 8
ENROLLMENT ... 8
TIMELY ENROLLMENT ... 9
OPEN ENROLLMENT ... 9
SPECIAL ENROLLMENT PERIODS ... 9
EFFECTIVE DATE ... 11
TERMINATION OF COVERAGE ... 11
CONTINUATION DURING PERIODS OF EMPLOYER CERTIFIED DISABILITY OR LEAVE OF ABSENCE 12
REHIRING A TERMINATED EMPLOYEE ... 13
EMPLOYEES ON MILITARY LEAVE ... 14
SURVIVOR DEPENDENTS ... 14
SCHEDULE OF BENEFITS ... 15
COMPREHENSIVE MEDICAL BENEFITS ... 15
PLAN FEATURES ... 18
PREVENTIVE CARE ... 20
HOSPITAL AND OTHER FACILITY EXPENSE BENFITS ... 23
MEDICAL/SURGICAL SERVICES AND SUPPLIES ... 32
PRESCRIPTION DRUG BENEFITS ... 42
VISION CARE BENEFITS (PROVIDER CHOICE OPTION ONLY) ... 44
COST MANAGEMENT SERVICES ... 45
HOW THE PROGRAM WORKS ... 45
PRECERTIFICATION ... 46
CONCURRENT REVIEW, DISCHARGE PLANNING ... 47
MEDICAL PROCEDURE REVEW (PROVIDER CHOICE OPTION ONLY) ... 47
PROSPECTIVE PROCEDURE AND PLAN REVIEW (TRADITIONAL OPTION ONLY) ... 48
CASE MANAGEMENT ... 48
UTILIZATION REVIEW ... 49
COMPREHENSIVE MEDICAL BENEFITS ... 51
DEDUCTIBLE ... 51
BENEFIT PAYMENT ... 51
OUT-OF-POCKET LIMIT ... 51
OUT OF COUNTRY CARE ... 51
COORDINATION OF BENEFITS ... 52
COVERED CHARGES ... 52
INDEXING (PROVIDER CHOICE OPTION ONLY) ... 52
PREVENTIVE CARE ... 53

WELL CHILD CARE 53
WELL ADULT CARE 53
HOSPITAL AND OTHER FACILITIES 54
INPATIENT ACUTE CARE HOSPITAL 54
BIRTHING CENTER 54
INPATIENT MENTAL DISORDER CARE 55
INPATIENT SUBSTANCE USE DISORDER CARE 56
OUTPATIENT HOSPITAL SERVICES 56
AMBULANCE CHARGES 57
AMBULATORY SURGICAL CENTER 57
INPATIENT SKILLED NURSING FACILITY CARE 58
OUTPATIENT SKILLED NURSING FACILITY CARE 58
HOME HEALTH CARE 59
HOSPICE CARE 60
URGENT CARE FACILITY 60
MEDICAL/SURGICAL SERVICES AND SUPPLIES 61
SURGICAL CHARGE BENEFITS 61
AMBULATORY SURGERY BENEFIT (TRADITIONAL OPTION ONLY) 61
MULTIPLE SURGICAL PROCEDURE CHARGES 61
ASSISTANT SURGEON CHARGES 62
ANESTHESIA 62
MATERNITY CARE 62
RECONSTRUCTIVE SURGERY 63
TRANSPLANTS 63
IN-HOSPITAL/FACILITY PHYSICIANS' CARE BENEFITS 64
SPECIALIST CONSULTATIONS 64
OUTPATIENT PHYSICIAN CARE 65
FOOT CARE AND PODIATRY SERVICES 65
DIAGNOSTIC TESTING X-RAY AND LAB CHARGE BENEFITS 65
ALLERGY CARE 66
KIDNEY DIALYSIS 66
RADIATION THERAPY 66
CHEMOTHERAPY 66
OUTPATIENT TREATMENT OF MENTAL DISORDERS 67
OUTPATIENT TREATMENT FOR SUBSTANCE USE DISORDER 67
PHYSICAL THERAPY 68
SPEECH THERAPY 68
OCCUPATIONAL THERAPY 68
CARDIAC REHABILITATION 68
INHALATION/RESPIRATORY THERAPY 68
DURABLE MEDICAL EQUIPMENT (DME) 68

PROSTHETICS 69
ORTHOTICS 69
OXYGEN 69
MEDICAL SUPPLIES (HOME USE) 69
BLOOD SERVICES 69
CONTACT LENSES/EYEGLASSES FOLLOWING INTRAOCULAR SURGERY 69
LIMITED DENTAL CARE 70
HEARING AIDS 70
DIABETIC SUPPLIES, EQUIPMENT AND EDUCATION 70
CHIROPRACTIC CARE 71
INFERTILITY 71
PHARMACY PRESCRIPTION DRUG BENEFITS 72
CARE TEAM CONNECT™FOR HEALTH 73
DEFINED TERMS 74
PLAN EXCLUSIONS 86
PRESCRIPTION DRUG BENEFITS 93
PHARMACY DRUG CHARGE 93
COPAYMENTS 93
PREAUTHORIZATION REQUIREMENTS 93
VOLUNTARY GENERIC DRUG SUBSTITUTION PROGRAM 94
PREFERRED/NON-PREFERRED BRAND NAME DRUGS 94
NETWORK PHARMACY 94
OUT-OF-NETWORK PHARMACY 95
MAIL ORDER DRUG BENEFIT OPTION 95
WHEN ANOTHER PLAN IS PRIMARY 96
COVERED PRESCRIPTION DRUGS 96
LIMITS TO THIS BENEFIT 97
EXPENSES NOT COVERED 97
VISION CARE BENEFITS (PROVIDER CHOICE OPTION ONLY) 99
BENEFIT PAYMENT 99
VISION CARE CHARGES 99
LIMITS 99
NETWORK VISION CARE PROVIDER 99
OUT-OF-NETWORK VISION CARE PROVIDER 100
HOW TO OBTAIN SERVICES OR BENEFITS 100
VISION CARE INQUIRIES 101
VISION CARE BENEFIT EXCLUSIONS 101
HOW TO SUBMIT A CLAIM 102
PRESCRIPTION DRUG BENEFIT CLAIMS 102
NETWORK PHARMACY 102
MEDICAL BENEFIT CLAIMS 102

WHEN CLAIMS SHOULD BE FILED 104
LEGAL PROCEEDINGS 104
CLAIMS APPEAL PROCEDURE 104
DENIAL DUE TO MEDICAL NECESSITY OR INVESTIGATIONAL 104
UTILIZATION REVIEW 104
STANDARD CLAIM APPEALS PROCEDURE 106
EXTERNAL APPEALS PROCEDURES 107
COVERED SERVICES/EXCLUSIONS 110
COORDINATION OF BENEFITS 111
MEDICARE 114
THIRD PARTY RECOVERY PROVISION 115
CONTINUATION COVERAGE RIGHTS UNDER COBRA 115
RESPONSIBILITIES FOR PLAN ADMINISTRATION 121
PLAN ADMINISTRATOR 121
DUTIES OF THE ADMINISTRATOR 121
PLAN ADMINISTRATOR COMPENSATION 121
CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY 121
FUNDING THE PLAN AND PAYMENT OF BENEFITS 122
PLAN IS NOT AN EMPLOYMENT CONTRACT 122
CLERICAL ERROR 122
MISREPRESENTATION/FRAUD 122
AMENDING AND TERMINATING THE PLAN 122
HIPAA COMPLIANCE 123
GENERAL PLAN INFORMATION 124

INTRODUCTION

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

This document is a description of Jefferson-Lewis et. al. School Employees' Healthcare Plan (the Plan). No oral interpretations can change this Plan. The Participating Employer Schools (hereinafter Participating Schools) have designated a Plan that provides health benefits for a broad range of medical services. Several features have been included in the Pan to manage costs for both you and the Participating Schools and to ensure that the health care you receive is within Plan guidelines. Plan payments are self-funded by Jefferson-Lewis et. al. through Participation Contribution by the Plan Enrollees (or participants) and allocations (money set aside) by the Participating Schools.

Coverage under the Plan will take effect for an eligible Employee/Retiree and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

This Plan has two options for benefit levels, the Traditional Option and the Provider Choice Option. The Plan benefits will be based on the provisions and limitations of the Plan option chosen by the Employee/Retiree at the time of his or her enrollment or enrollment changes. Plan differences for the Traditional Option and the Provider Choice Option will be shown when applicable.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or Amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit Coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, and eligibility.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of Coverage or no Coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, Medical Necessity, failure to timely file claims, or lack of Coverage.

The Plan will pay benefits only for the expenses Incurred while this Coverage is in force. An expense for a Service or Supply is Incurred on the date the Service or Supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, Amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination, Amendment or elimination.

This Plan is constructed pursuant to New York State Insurance Law, Article 47. This document, which describes the Plan's provisions, is subject to approval by the New York State Department of Insurance. The benefits, terms and conditions could change without notice pending its review. Only the Plan Administrator may change or Amend this Plan. Changes may be made at anytime by the Plan Administrator upon approval of the New York State Superintendent of Insurance. Any changes in the New York State Insurance Law that affect this Plan will automatically apply and the Plan will be so Amended.

This Plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the NYS Superintendent of Insurance. Participating Schools participating in the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan are subject to contingent assessment liability.

This SPD updates and replaces all previous publications or manuals showing Coverage for the self-funded Jefferson-Lewis et. al. Schools Employees' Healthcare Plan. It is a restatement of Plan benefits and includes Plan changes through July 1, 2011. For expenses Incurred before July 1, 2011, refer to prior Plan publications or contact the Plan Manager or the Claims Administrator if you need assistance.

This document describes the Plan rights and benefits for Covered Employees, Retirees and their Covered Dependents and is divided into the following parts:

Eligibility, Funding, Enrollment, Effective Date and Termination. Explains eligibility for Coverage under the Plan, funding of the Plan and when the Coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is Covered under more than one Plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of Injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's Coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Each Participating School in Jefferson Lewis et. al. has its own rules concerning Effective Dates and Waiting Periods. The healthcare clerk at your Participating School can provide full details concerning the Effective Date of benefits for Employees/Retirees and their eligible Dependents.

Eligible Classes of Employees. Persons in the following categories are considered Employees eligible for Plan enrollment:

(1) Regular full-time Employees of a Participating School according to that school's established rules for active Employee Plan enrollment.

(2) Former Employees who meet his or her Participating School's established rules for retirement and eligibility for Retiree Plan enrollment.

Eligibility Dates for Employee Coverage. Coverage begins at 12:01 A.M. on the designated Effective Dates for eligible Employees and/or their eligible Dependents. The following are general rules for Effective Dates of benefits:

(1) New Employee Eligibility Dates. The eligibility date for Plan enrollment is the date the Participating School has established for this Plan. Some Participating Schools may require different employment Waiting Periods to establish eligibility dates. The healthcare clerk at your Participating School can give you details on their rules for enrollment and on the date the enrollment application is accepted.

(2) Retirees on the Effective Date of the Plan. Each Retiree in an eligible class will be Covered on the date of the school's participation in this Plan if he or she enrolls within 30 days after the date of the school's participation and he or she was enrolled in the previous plan that was replaced by this Plan.

(3) Employed on the Effective Date of the Plan. Each Employee in an eligible class who was employed by the school on or before the date the school became a Participating School in this Plan, will be Covered on the date of the school's participation if the Employee enrolls within 30 days after the date of the school participation; and:

- **(a)** He or she was continuously employed by the Participating School at least 30 consecutive calendar days at the time this Plan became effective; or

- **(b)** He or she was eligible and enrolled in the Participating School's previous plan that was replaced by this Plan when this Plan went into effect.

(4) Employment after Effective Date of Plan. Effective Dates of Plan Coverage for Employees who start eligible employment after the Participating School becomes a participant in this Plan are as follows:

- **(a)** For Employees whose enrollment application is accepted by the Participating School before or on the date of eligibility for Plan enrollment, Coverage becomes effective on the date of their eligibility.

- **(b)** For Employees whose enrollment application is accepted by the Participating School within 30 days after the date of their eligibility for Plan enrollment, Coverage becomes effective on the date their Plan enrollment application is accepted.

- **(c)** Employees must be in eligible Employment Status with the Participating School on the date their Coverage becomes effective.

(5) Late Entrants. Employees, who do not enroll within 30 days after their date of eligibility, will be considered Late Entrants. Late Entrants can only request Plan enrollment during the Plan open enrollment period or a special enrollment period. See “Open Enrollment” and “Special Enrollment Periods” shown later in this section.

Persons not Eligible. Persons in the following categories are not considered Employees eligible for Plan enrollment.

(1) Any terminated or laid-off Employee who was not enrolled in the Plan at the time active employment ended and who was not eligible as a Retiree.

(2) Per diem/casual Employees; persons hired on a temporary basis or student interns.

(3) Any non-enrolled Employee who submits an initial application while temporarily removed from the payroll.

(4) Any persons on active duty in the military service or armed forces of any government or country may be deemed ineligible, unless, within 60 days of being ordered to active duty, the Employee is otherwise eligible and enrolled, and makes a written election to the Participating School to continue coverage under the Plan.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A Covered Employee's/Retiree’s Spouse. The term "Spouse" shall mean the person recognized as the covered Employee's/Retiree’s:

(a) husband or wife of the opposite gender under the laws of the state where the covered Employee/Retiree lives, and must be a resident of the same country in which the Covered Employee/Retiree resides; or

(b) husband or wife of the same gender when there has been a marriage which is legally valid in the jurisdiction in which it occurred and the couple possesses a valid marriage license or certificate from that jurisdiction, and must be a resident of the same country in which the Covered Employee/Retiree resides.

The Plan Administrator may require documentation proving a legal marital relationship.

Note: Individuals who apply for same-gender Spouse coverage, are encouraged to consult with a tax attorney or accountant concerning the implications of seeking coverage in the Plan. As same gender Spouses are not usually recognized as dependents by some taxing authorities, providing coverage to a same-gender Spouse could result in additional tax liability. Your Employer could be required to report the fair market value of the coverage as income on an Active Employee’s W-2 form

(2) A Covered Employee’s/Retiree’s Dependent children.

(a) Married and unmarried children from birth to the limiting age of 26 years who are the biological children of the Employee/Retiree, adopted children, child placed with a Covered Employee/Retiree in anticipation of adoption or Foster Children. Step-children (from same gender or opposite gender marriage) may also be included as long as the biological parent remains married to the Employee/Retiree. Any other child for whom the Employee/Retiree is the legal guardian; or the Employee’s/Retiree’s Spouse (as long as the Spouse remains married to the Employee/Retiree) is the legal guardian; and provided such guardianship commenced before the child reached age 19.

The Dependent child age 19 or older must not be eligible for coverage or covered under another employer group health plan, fund or policy. This restriction expires January 1, 2014. **Exception:** Coverage of the Dependent young adult child under the other parent’s group health plan, fund or policy is allowed. When the child reaches the limiting age, Coverage will end on their birthday or on an earlier date if the Dependent young adult child becomes eligible under another

employer group health plan that is not their parent's employer group health plan. A newborn is eligible from the moment of birth if enrolled in family Coverage.

The phrase "child placed with a Covered Employee/Retiree in anticipation of adoption" refers to a child whom the Employee/Retiree intends to adopt, whether or not the adoption has become final, who has not attained the age of 19 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee/Retiree of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(b) Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent Coverage under this Plan. You will be required to pay any added monthly participation costs for the child's enrollment.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(c) A Covered Dependent child who reaches the limiting age and is Totally Disabled (incapable of self-sustaining employment by reason of mental Illness, developmental disability, mental retardation, as defined in the New York State Mental Hygiene Law or physical handicap), "primarily dependent upon" the Covered Employee/Retiree and/or Covered Employee's/Retiree's Spouse for support and maintenance and unmarried. Eligibility for Plan Coverage remains in effect while so disabled. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

The phrase "primarily dependent upon" shall mean dependent upon the Covered Employee/Retiree and/or Covered Employee's/Retiree's Spouse for at least 50% financial support and the Covered Employee/Retiree must declare the child as an income tax deduction under the current United States federal income tax rules.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The eligibility of such a Dependent should be established as early as possible. This should be done during your initial enrollment if the disabled child is the limiting age or older, at the time. After initial enrollment, the Covered Employee/Retiree must request disabled-child-continuation within 31 days after the child reaches the limiting age. Failure to do so could result in loss of eligibility and benefits.

(d) An unmarried child over the limiting age can be Covered under the Covered Employee's/Retiree's (parent's) employee health plan through age 29, even if he or she is not financially dependent on the parent, or does not live with the parent, or is a not a student. This is called the "Young Adult Option". The following criteria must be met:

(i) The parent must be Covered under the Plan as an Employee; and

(ii) The Dependent cannot be covered under or be eligible for any other employer sponsored group health plan or policy or be covered under Medicare; and

(iii) The Dependent must reside or work in New York State; and

(iv) Be under 29 years of age.

A Dependent child or the Employee parent who elects to continue Coverage under this "Young Adult Option" is responsible for the cost of single coverage, as designated by the Employer.

The Employee or dependent child must apply in writing (and submit the first month's full individual contribution):

- Within 60 days following termination of coverage due to the Plans limiting age for a Dependent child;
- Within 60 days of newly meeting the Plan's definition of Dependent child;
- During the Plan's annual open enrollment period;
- If the child's coverage has already terminated due to limiting age, coverage may also be elected on a prospective basis within 12 months after the effective date of this provision.

If the child enrolls within the time periods described above, the extension of coverage will be effective:

- retroactive to the date that coverage was terminated due to reaching the limiting age.
- Otherwise, coverage will begin within 30 days following the date the Participating School receives the application and full contribution for Coverage.

This extension of coverage terminates when the Dependent child becomes eligible under another group health policy or plan, is married, reaches age 29, or no longer resides or works in New York State. The Dependent child is **not** eligible for COBRA continuation of coverage.

If a child's extension of coverage terminates, he or she may be eligible to re-enroll under this provision if he or she meets the Plan's definition of a Dependent child and either enrolls within 60 days or during an open enrollment period.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records (if applicable) or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the Covered Employee's/Retiree's home, but who are not eligible as defined; the legally divorced former Spouse of the Employee/Retiree; or any person who is enrolled as an eligible Employee or Retiree under any health plan sponsored by Jefferson–Lewis et. al. or by their Participating School.

If both mother and father are Employees/Retirees, their children will be Covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee/Retiree will become eligible for Dependent Coverage on the first day that the Employee/Retiree is eligible for Employee/Retiree Coverage and the family member satisfies the requirements for Dependent Coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

If a person Covered under this Plan changes status from Employee/Retiree to Dependent or Dependent to Employee, and the person is Covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

FUNDING

Cost of the Plan. You may be required to pay a Participation Contribution to maintain Plan Coverage. For active Employees this is usually done by monthly payroll deductions. Your Participating School may ask you to sign an authorization for such deductions. Failure to authorize such payroll deductions could result in denial of your Plan Coverage. If your payment is not done by payroll deduction, you must pay your designated Participation Contribution, usually due monthly, to maintain Plan Coverage. Failure to pay your Participation Contribution within 30 days after the due date could result in a lapse or cancellation of Plan Coverage. The healthcare clerk at your Participating School can give you information concerning your costs for Plan participation. Periodically, the Plan Administrator will evaluate Plan costs for claim payments and administration to establish or change the amounts to be contributed by you, if any.

The level of any Enrollee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Enrollee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for Employee-only or Dependent Coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization, if applicable.

No person may be eligible for enrollment both as an Employee/Retiree and as a Dependent, or as a Dependent of more than one Employee or Retiree, or enrolled as a participant more than once in this Plan. No Employee or Retiree can enroll in more than one health plan sponsored by his or her Participating School. The healthcare clerk at your Participating School can provide forms and explanations needed for any enrollment updates or changes. Failure to report enrollment changes could result in Plan benefit overpayment. Should this happen, you may be required to reimburse in full the amount of the overpayment.

Enrollment in the Plan is not automatic. You are required to enroll yourself and your Dependents. You must meet the Plan eligibility requirements in effect at the time you request enrollment. Your enrollment options are as follows:

(1) Traditional Option or Provider Choice Option. You may elect to enroll in either Plan Option at the time of your initial enrollment. However, once enrolled, you cannot change your Plan Option until an open enrollment period.

(2) Individual or Personal Coverage. Employee, Retiree, survivor Spouse or a COBRA participant is enrolled. Plan covers only that eligible and enrolled person.

(3) Family Coverage. Employee or Retiree and one or more eligible Dependents are enrolled. It also includes survivor Spouse, or ex-Spouse and one or more of his or her eligible Dependents under COBRA. Refer to the section entitled “Continuation Coverage Rights under COBRA” found later in this document. Individual Coverage provides benefits for the eligible enrolled Employee or Retiree, Spouse or ex-Spouse; and enrolled eligible Dependents. Family Coverage participation costs will be based on the following enrollment choices:

- **(a)** Employee or Retiree and Spouse are enrolled.
- **(b)** Employee or Retiree and one Dependent child are enrolled (surviving Spouse or ex-Spouse and one Dependent child under COBRA).
- **(c)** Employee or Retiree and Spouse and one or more Dependent children (surviving Spouse or ex-Spouse and two or more Dependent children under COBRA).

If the Covered Employee already has Dependent Coverage, separate enrollment for a Newborn child is required.

If you have individual Coverage, at the time you acquire a new Dependent; you must change to family Coverage and pay the applicable family Coverage Participation Contribution within 30 days after the Dependent was acquired.

Enrollment Requirements for Newborn Children.

A Newborn child of a Covered Employee/Retiree who has Dependent Coverage is not automatically enrolled in this Plan. If the Newborn child is not enrolled in this Plan on a timely basis, as defined in the subsection entitled "Timely Enrollment" following this subsection, there will be no payment from the Plan and the Covered parent will be responsible for all costs for the Newborn child.

Note: Under Federal law and New York State Insurance Law, group health Plans may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. In any case, Plans cannot require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

TIMELY ENROLLMENT

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the Coverage, either initially or under a Special Enrollment Period.

If two Employees/Retirees (husband and wife) are Covered under the Plan and the Employee covering any Dependent children terminates Coverage, the Dependent Coverage may be continued by the other Covered Employee/Retiree; no Waiting Period is required if Coverage has been continuous.

OPEN ENROLLMENT

Employees, enrolled Retirees and/or their Dependents who fail to enroll in the Plan at the time of initial eligibility may be enrolled during the Plans' open enrollment periods. Enrollment applications for Late Entrants may be made during the month of June in any given year. Coverage becomes effective at 12:01 A.M. on July 1, following the June enrollment. If the Employee is no longer in eligible employment on the scheduled Effective Date, his or her Plan Coverage will not be eligible for any Plan benefits.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of Coverage. Thus, the time between the date a special Enrollee first becomes eligible for enrollment under the Plan and the first day of Coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage. A person who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

- **(a)** The eligible person was covered under a group health plan or had health insurance coverage at the time Coverage under this Plan was previously offered to the individual.
- **(b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- **(c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

(d) The eligible person requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The eligible person has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.

(ii) The eligible person has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(iii) The eligible person has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The eligible person has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual).

(iv) The eligible person has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the eligible person lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee/Retiree is a participant under this Plan (or the Employee is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee/Retiree through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a Covered Dependent of the Covered Employee/Retiree. In the case of the birth or adoption of a child, the Spouse of the Covered Employee/Retiree may be enrolled as a Dependent of the Covered Employee/Retiree if the Spouse is otherwise eligible for Coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The Coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(i) in the case of marriage, as of the date of the marriage;

(ii) in the case of a Dependent's birth, as of the date of birth; or

(iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009.

Employees and dependents who are eligible for, but not enrolled, in this Plan may also enroll in this Plan when:

(a) the Employee or Dependent loses eligibility under Medicaid or the state's Children's Health Insurance Program (CHIP), and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after the date of termination of coverage; or

(b) the Employee or Dependent becomes eligible for premium assistance under Medicaid or the state's Children's Health Insurance Program (CHIP) to subsidize the cost of coverage in this Plan, and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after eligibility for a premium assistance subsidy is determined.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be Covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an active Employee (with Employment Status, as defined by this Plan) for this Coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's Coverage will take effect on the day that the Eligibility Requirements are met; the Employee/Retiree is Covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When Coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Coverage under this Plan. Please contact the healthcare clerk at your Participating School for further details.

When Employee Coverage Terminates. Employee Coverage will terminate on the earliest of these dates (except in certain circumstances, a Covered Employee may be eligible for COBRA continuation Coverage. For a complete explanation of when COBRA continuation Coverage is available, what conditions apply and how to select it, see the section entitled "Continuation Coverage Rights under COBRA"):

(1) The date the Plan is terminated.

(2) The day the Covered Employee/Retiree ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the Covered Employee. (See the "Continuation Coverage Rights under COBRA".)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Plan Cancellation

If a Participating School cancels its participation in Jefferson-Lewis et. Al., Coverage ends for all of its Employees/Retirees and Dependents at 12:01 A.M. on the day following the cancellation date. If this Plan cancels, Coverage ends for all persons enrolled in the Plan at 12:01 A.M. on the day following the Plan cancellation date. Written notice of such cancellations will be sent to the affected participants at least 90 days before the date of the Plan cancellation.

When Dependent Coverage Terminates. A Dependent's Coverage will terminate on the earliest of these dates (except in certain circumstances, a Covered Dependent may be eligible for COBRA continuation Coverage. For a complete explanation of when COBRA continuation Coverage is available, what conditions apply and how to select it, see the section entitled "Continuation Coverage Rights under COBRA"):

(1) The date the Plan or Dependent Coverage under the Plan is terminated.

(2) The date that the Employee's/Retiree's Coverage under the Plan terminates for any reason including death. (See "Survivor Dependents"; "Continuation Coverage Rights under COBRA".)

(3) The date a Covered Spouse loses Coverage due to loss of dependency status. (See the "Continuation Coverage Rights under COBRA".)

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the "Continuation Coverage Rights under COBRA".)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

CONTINUATION DURING PERIODS OF EMPLOYER-CERTIFIED DISABILITY OR LEAVE OF ABSENCE

The healthcare clerk at your Participating School can provide details on your rights and costs for continued Coverage while out of work due to disability or for an approved Leave of Absence. Each Participating School may allow the continuation according to its established rules which preclude individual selection. This Plan will be compliant with Title 11 NYCRR § 52.18 (b).

You may retain your individual Coverage or family Coverage under the Plan for an approved Leave of Absence due to disability or other leave approved by your Participating School according to its established rules or under the Family and Medical Leave Act shown below. If any part of the leave is without pay, you must submit your designated Participation Contributions on a timely basis to maintain Coverage. If you continue to be absent from work beyond the approval period, your Plan Coverage will end at midnight on the last day of your approved absence. However, you and your Dependents may be eligible for continuation armed forces reservist on active duty coverage or "Continuation Coverage Rights under COBRA".

If you fail to pay a scheduled Plan Participation Contribution within 30 days of the due date, Coverage will end for you and your Dependents at the end of the month for which your last Participation Contribution was made. If Plan Coverage ends while you are absent from work, you cannot be reinstated until you return to work and enroll in the Plan. You will be considered a new Employee if more than 60 days have passed since your last day of approved absence.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain Coverage under this Plan on the same conditions as Coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan Coverage terminates during the FMLA leave, Coverage will be reinstated for the Employee and his or her Covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave.

Coverage will be reinstated only if the person(s) had Coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that Coverage terminated.

Extension of Coverage Due to Total Disability. Please contact the healthcare clerk at your Participating School, if you have any questions or concerns regarding Total Disability requirements. Extension of Coverage is not available for Covered Persons who are Covered under the Plan's Continuation of Coverage under COBRA or active military reservist continuation.

(1) 31-Day Limited Total Disability Extension. This extension of Coverage applies when Plan Coverage ends due to termination of eligible active employment with the Participating School or termination of the Covered Person's eligibility or termination of the Plan unless the Covered Person is Covered by a Participating School Health Plan replacing this Plan. An extension of benefits will be provided during a period of Total Disability for Hospital Confinements commencing or Surgery performed during the next 31 days for the Injury, Illness or Pregnancy causing the Total Disability. If eligibility ended due to termination of eligible active employment, the 12-Month Total Disability Extension shown below could be applicable.

(2) 12-Month Total Disability Extension. This extension applies when Coverage ends due to termination of eligible active employment and runs concurrent with the 31-Day Limited Total Disability Extension shown above.

Coverage Limits. Extension of Coverage for Total Disability provides continued Coverage for you or your eligible Dependents who are Totally Disabled at the time Coverage would otherwise end due to termination of eligible active employment with the Participating School. This extended Coverage provides benefits solely for expenses Incurred for the Illness, Injury or Pregnancy causing the Total Disability up to a maximum period of 12 consecutive months subsequent to termination of Coverage. However, this extended Coverage does not apply if Coverage is available for those expenses under another group health Plan.

End of Extended Coverage. Plan Coverage under this provision will remain in effect until the earliest of the following dates:

(a) The date the Covered Person is no longer Totally Disabled;

(b) The date the maximum benefits under the Plan have been received;

(c) The date the Covered Person obtains coverage under another group health plan which provides coverage for the disabling condition; or

(d) The end of 12 consecutive months from the date Coverage under the Plan would otherwise terminate.

You or your Dependent must submit an attending Physician's certificate of Total Disability to the healthcare clerk in your Participating School. You will be advised, in writing, whether or not extension of Coverage has been approved. If extension of Coverage is approved, additional proof of Total Disability could be requested from time to time.

REHIRING A TERMINATED EMPLOYEE

A terminated Employee will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service may elect to continue Plan Coverage as mandated, and as amended by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents Covered under the Plan before leaving for military service.

(1) The maximum period of Coverage of a person under such an election shall be the lesser of:

  (a) The 24 month period beginning on the date on which the person's absence begins; or

  (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health Plan Coverage may be required to pay up to 100% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the Coverage .

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of Coverage upon reemployment if one would not have been imposed had Coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for Coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the healthcare clerk at your Participating School. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health Plan continuation.

SURVIVOR DEPENDENTS

If you die, your survivor Dependents could be eligible to continue Plan enrollment under his or her own individual Coverage. Each Participating School has different rules concerning survivor Dependent eligibility. Your Participating School’s healthcare clerk can provide details concerning their rules for survivor Dependent eligibility. If your survivor Dependent is not eligible for this enrollment, she or he may be eligible for COBRA. See the “Continuation Coverage Rights under COBRA”.

SCHEDULE OF BENEFITS

Verification of Eligibility 1-888-201-5150

Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

COMPREHENSIVE MEDICAL BENEFITS

All benefits described in this schedule are subject to the exclusions and limitations described more fully herein including, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that Services, Supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the "Defined Terms" section of this document.

Note: If this Plan is primary the following Services for the **Provider Choice Option must be precertified** or reimbursement from the Plan may be reduced. For the **Traditional Option, precertification is voluntary.**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Precertification of the Medical Necessity for the following non-emergency Services before medical and/or surgical Services are provided:

Hospitalizations
Substance Use Disorder/Mental Disorder Inpatient admissions
Skilled Nursing Facility stays
Home Health Care

Medical procedure review for the Provider Choice Option, and prospective procedure and plan review for the Traditional Option is voluntary and you are encouraged to call the POMCO Benefit Management Unit for assistance in making decisions concerning your options and Plan Coverage for certain kinds of procedures and treatment plans.

Traditional Option only:
Oxygen and oxygen equipment
Rehabilitative Services (cardiac, physical, occupational or speech therapy)
Rental/purchase of Durable Medical Equipment
Outpatient Surgery
Kidney Dialysis

Provider Choice Option only:
Dilatation and Curettage (D & C unrelated to Pregnancy)
Weight reduction surgical procedures
Knee joint repair/replacement
MRA (magnetic resonance angiography)
MRI (magnetic resonance imaging)
PET scans
Varicose vein Surgery

Please see the Cost Management section in this booklet for details.

NETWORK PROVIDERS

The Plan is a plan which contains a Network Provider Organization.

PPO name:	POMCO/PHCS/Multiplan Network
Address:	2425 James Street Syracuse, NY 13206
Telephone:	1-888-201-5150
Website:	www.benefitsoft.com (click on "Provider Finder")

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons Covered under the Plan, the Plan agrees to reimburse the Provider directly for Covered Services. You may contact the healthcare clerk at your school. Additional information about these Networks, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request.

For the Traditional Option: The Network Providers under this Option have agreed not to balance bill for charges more than the Allowed Charges for Covered Services or Supplies. Generally, you will only be responsible for payment of applicable Deductibles, Percentage Coinsurance amounts and any charges that exceed Plan Coverage limits.

For the Provider Choice Option: The Network Providers under this Option have agreed not to balance bill for charges more than the Allowed Charges for Covered Services or Supplies. Generally, you will only be responsible for any applicable Network or Benefit Copayments and any charges that exceed Plan Coverage limits.

OUT-OF-NETWORK PROVIDERS

When you use an Out-of-Network Provider, Plan benefits are based on Usual, Reasonable, and Customary Charges as determined by the Claims Administrator. You will be responsible for payment of applicable Deductibles, Percentage Coinsurance amounts, benefit Copayments, charges that exceed Plan Coverage limits and charges more than the URC amount.

You or your Dependents may choose any Provider for medical care. However, because the Network allowances are generally lower than the Out-of-Network Providers, choosing Network Providers can result in substantial savings to you and the Plan. The Covered Services or Supplies for Network and Out-of-Network Providers are subject to the same limitations and exclusions, unless shown otherwise. It is the Covered Person's choice as to which Provider to use.

OUT OF COUNTRY CARE

This Plan will provide benefits for Covered expenses Incurred outside the USA. Plan benefits will be based on the currency exchange rate in effect at the time Services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of Service, charge for each Service (currency of the country if not in US dollars), date(s) of service, and name of country where Services are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the Enrollee directly.

COORDINATION OF BENEFITS

When Services and Supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the coordination of benefits provision and Medicare secondary payer rules, all benefits will still apply. Any applicable Network and benefit Copayments are waived.

DEDUCTIBLES/COPAYMENTS/OUT-OF-POCKET LIMIT PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A **Deductible** is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new Deductible amount is required. Deductibles do not accrue toward the 100% maximum Out-of-Pocket limit. However, for the Traditional Plan Option only Covered Charges Incurred in, and applied toward the Deductible in October, November and December will be applied to the Deductible in the next Calendar Year as well as the current Calendar Year.

A **Copayment** is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some Services and other Services will not have any Copayments. Copayments do not accrue toward the 100% maximum Out-of-Pocket limit.

The Out-of-Pocket Limit (OOP) is Covered Charges payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% of Allowed Charges (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% of Allowed Charges (except for the charges excluded) for the rest of the Calendar Year.

ALLOWED CHARGE(S)

Allowed Charges are the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered medical Services rendered and billed by a Covered Out-of-Network Provider.

(1) For the Traditional Option, Allowed Charges are based on the 50th percentile of current fee data profiles.

(2) For the Provider Choice Option, Allowed Charges are based on the 85th percentile of current fee data profiles.

If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan and or any applicable Copayments, Deductibles or Percentage Coinsurance amounts.

INDEXING-Provider Choice Option only

The Deductible and Percentage Coinsurance limit (OOP) are subject to change based on the aggregate increase or decrease in the cost of providing the health benefits under the Plan and a determination by the Plan Administrator. In making this determination, the Plan Administrator will take into account: The past Calendar Year Plan experience, the inflation index; the northeast medical component of the U.S. Consumer Price Index (CPI); and trends in the healthcare industry. Any such changes will be effective the following July 1. You will be notified before the effective date of any changes.

MEDICAL BENEFITS

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Comprehensive Medical Benefits, Plan Exclusions, and Definitions.			
Plan Features	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
Calendar Year Deductible	$266 per Individual. $798 per family (cumulative for three or more Covered Family Members).	Does not apply to most services. See individual Plan features for details and exceptions.	$399 per Individual. $1,197 per family (cumulative for three or more Covered Family Members).
Common Accident Deductible	$266 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. Expenses also count toward the Calendar Year individual and family limit Deductible.	Does not apply.	
Carry-over Individual Deductible	Covered Charges Incurred in, and applied toward the individual Deductible in October, November and December will be applied to the individual Deductible in the next Calendar Year as well as the current Calendar Year. Deductible reduction is based on the earliest Incurred date not the date the claim was submitted.	Does not apply.	
Network Copayment	Does not apply.	$24 (when shown). See individual Plan features for details and exceptions.	Does not apply.
Benefit Copayment	Does not apply.	Varies, see individual Plan features for details and exceptions.	
Percentage Coinsurance	After the Calendar Year Deductible, the Plan pays 80% of the Allowed Charges for most Covered Services and Supplies. See individual Plan features for details and exceptions.	The Plan pays 100% of the Allowed Charges for most Covered Services and Supplies. See individual Plan features for details and exceptions.	After the Calendar Year Deductible, the Plan pays 80% of the Allowed Charges for most Covered Services and Supplies. See individual Plan features for details and exceptions.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Comprehensive Medical Benefits, Plan Exclusions, and Definitions.			
Plan Features	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
Out-of-Pocket Limit (OOP) Excluding: Deductible, Copayments, non-Covered Charges and over URC amounts per Calendar Year	$799 per individual. $2,397 per family (cumulative for three or more Covered Family Members). After the Calendar Year Deductible, the Plan pays 80% of most Allowed Charges up to $3,995 for each Covered Person or $11,985 for three or more Covered Family Members; the Plan then pays 100% of the balance of the Allowed Charges for the remainder of the Calendar Year. See individual Plan features for details and exceptions.	Does not apply to most services. See individual Plan features for details and exceptions.	$771 per individual. $2,313 per family (cumulative for three or more Covered Family Members). After the Calendar Year Deductible, the Plan pays 80% of most Allowed Charges up to $3,855 for each Covered Person or $11,565for three or more Covered Family Members; the Plan then pays 100% of the balance of the Allowed Charges for the remainder of the Calendar Year. See individual Plan features for details and exceptions.
Cost Management Services Program/Pre-notification	This voluntary program for the Traditional Plan Option and mandatory program for the Provider Choice Plan Option requires a phone call before the Covered Person is admitted to a Hospital or other Covered facility as an Inpatient or before Home Health Care Services are scheduled to be performed. Please contact the POMCO Cost Management Program toll-free at 1-888-201-5150 or refer to the Cost Management section of this document for further information. For the Provider Choice Option a benefit reduction of 50% (to a $250 maximum) per Covered Inpatient Confinement will be applied for non-compliance with this requirement.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Preventive Care, Plan Exclusions, and Definitions.			
Preventive Care	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Well Child Care, Includes Age Appropriate Exams, Related Tests and Immunizations (from birth up to 19th birthday)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
	Coverage is intended to be consistent with the clinical standards set forth by the American Academy of Pediatrics (AAP) and standards set forth by New York State Insurance Law. Immunizations follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) and standards set forth by New York State Insurance Law.		
Routine Newborn Nursery Care (includes circumcision)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the Newborn child is Hospital-confined up to four days. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine Newborn care billed by an anesthesiologist or the delivering Physician is not Covered.		
Routine Adult Physical (includes exam and related tests)	100% of Allowed Charges Deductible does not apply. Related diagnostic tests are Covered if billed with or in relationship with a Covered physical exam. **Limited to:** **Employee and Spouse age 40 or older-**once per Calendar Year.	**Benefit is only available if this Plan is primary.** Exam: 100% of Allowed Charges after Network Copayment. 100% of Allowed Charges for related diagnostic tests billed with or in relationship with a Covered physical exam. **Limited to:** **Age 19 up to 50th birthday** -once every two Calendar Years. **Age 50 or older**- once per Calendar Year.	Not a benefit. In-Network only Coverage available.
Adult Immunizations (Age 19 or older)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
	Limited to adult immunizations for those Covered Persons that meet the Center for Disease Control (CDC) recommendations criteria for coverage. The current list of Covered adult immunizations include tetanus, diphtheria, pertussis (TD/Tdap), human papillomavirus (HPV), measles, mumps, rubella (MMR), varicella, influenza, pneumococcal (polysaccharide), hepatitis A, hepatitis B, and meningococcal. If the CDC protocol standards change, the Plan will automatically cover the new recommended standards and immunizations.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Preventive Care, Plan Exclusions, and Definitions.			
Preventive Care	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Routine Mammography Screening Including Professional Interpretation	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.
	Limited to: **(1)** Mammography, recommended by a Physician for Covered Persons, at any age, having a prior history of breast cancer, or who have a first degree relative with a prior history of breast cancer. **(2)** A single baseline mammography for Covered Persons 35-39 years of age. **(3)** An annual mammography for Covered Persons 40 years of age or older. In no event, will the Plan pay for more than one routine mammography screening in any one Calendar Year. Includes Services rendered in a Hospital Outpatient setting, clinic or Physician's office.		
Routine Gynecological Exam, and Cervical Cancer Screening (Female age 18 and older)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.
	Limited to: Once every Calendar Year. Services include gynecological exam (pelvic and breast) and related testing. Related testing to include, but is not limited to collecting and preparing pap smears, and the laboratory diagnostic service to examine and evaluate the pap smear. This benefit includes Services rendered in a Hospital Outpatient setting, clinic or Physician's office.		
Routine Prostate Cancer Screening	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.
	Coverage is provided for standard diagnostic testing (examples- digital rectal examination, and a prostate-specific antigen test) for eligible males as follows: **(1)** An annual routine screening for eligible males, age 40 or older, with a family history of prostate cancer or other prostate cancer risks. **(2)** An annual routine screening for eligible males, age 50 or older, who are without symptoms of prostate cancer. **(3)** Diagnostic testing for men of any age who have a prior history of prostate cancer. Includes Services rendered in a Hospital Outpatient setting, clinic or Physician's office.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Preventive Care, Plan Exclusions, and Definitions.			
Preventive Care	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Bone Mineral Density Measurement & Tests	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.
	Limited to: Once every two Calendar Years for routine screening based on age, sex and family history. Tests must meet the criteria of the federal Medicare program and the National Institutes of Health (example- dual-energy absorptiometry). The attending Physician must order the testing. More frequent testing is Covered and payable under the diagnostic X-ray benefit if found Medically Necessary for the following conditions: **(1)** Women who are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on their medical history and other findings; **(2)** Men or women whose X-rays show previous fractures; **(3)** Men or women on prednisone or steroid-type drugs or who are planning such treatment or other drug regimen posing significant risk of osteoporosis; **(4)** Men and women diagnosed with primary hyperparathyroidism; **(5)** Men and women being treated with a drug for osteoporosis, to see if it is working (Covered as a treatment of Illness, not a screening); **(6)** Men or women with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; diagnosed as having osteoporosis or having a family history of osteoporosis; **(7)** With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or **(8)** With such age, gender and/or other physiological characteristics which pose a significant risk of osteoporosis.		

<table>
<tr><td colspan="4">The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.</td></tr>
<tr><td rowspan="3">Hospital and other Facility Expense Benefits</td><td>Traditional Option</td><td colspan="2">Provider Choice Option</td></tr>
<tr><td>(POMCO/PHCS/MultiPlan)</td><td>In-Network Benefits (POMCO/PHCS/MultiPlan)</td><td>Out-of-Network Benefits</td></tr>
<tr><td colspan="3">Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.</td></tr>
<tr><td>Inpatient Acute Care General Hospital Services (facility charges)

Medical, Surgical, and Maternity Care

Maternity is Covered the same as any other Illness and includes one home visit for early discharge when Coverage criteria is met.

Newborn care is Covered from the moment of birth if the child is enrolled under family Coverage (routine or sick care).

Routine Newborn Nursery Care is limited to the first four days. After four days, continued care must be for treatment due to an Illness of the Newborn that required Inpatient Care.</td><td>Precertification suggested.
100% of Allowed Charges, limited to 365 benefit days per Spell of Illness. Deductible does not apply. Additional benefits available at 80% of Allowed Charges, after Deductible. Percentage Coinsurance Out-of-Pocket limit applies once Spell of Illness maximum is met. See separate limit for Mental Disorder and Substance Use Disorder Inpatient Care shown below.

Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary.

Non-Medically Necessary private room charges that are more than the Covered Average Semi-Private Room Rate will be allowed at 80% of the Allowed Charges (up to $10 per day), after Deductible. Percentage Coinsurance Out-of-Pocket limit applies.</td><td colspan="2">Precertification required.
100% of Allowed Charges, after $131 per Continuous Confinement Inpatient Benefit Copayment. Limited to 365-benefit days per Spell of Illness. Deductible does not apply to Out-of-Network Allowed Charges. See separate limit for Mental Disorder and Substance Use Disorder Inpatient Care shown below.

Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary. You will be responsible for payment of charges that are more than the Hospital Average Semi-Private Room Rate if the private room is not found to be Medically Necessary.

If transferred from one Inpatient Hospital/facility to another Inpatient Hospital/facility only one Benefit Copayment will apply.</td></tr>
<tr><td>Certified Birthing Centers</td><td colspan="3">Covered on the same basis as Acute Care General Hospitals. Includes Routine Newborn Nursery Care.</td></tr>
</table>

<table>
<tr><td colspan="4">The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.</td></tr>
<tr><td rowspan="3">Hospital and other Facility Expense Benefits</td><td>Traditional Option</td><td colspan="2">Provider Choice Option</td></tr>
<tr><td>(POMCO/PHCS/MultiPlan)</td><td>In-Network Benefits (POMCO/PHCS/MultiPlan)</td><td>Out-of-Network Benefits</td></tr>
<tr><td colspan="3">Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.</td></tr>
<tr><td>Inpatient Mental Disorder Care (facility charge)
• Hospital or Psychiatric Facility
• Partial Hospitalization

Two Partial Hospitalization days count as one Hospitalization day</td><td>Precertification suggested.
100% of Allowed Charges, limited to 365 benefit days per Spell of Illness. Deductible does not apply. Additional benefits available at 80% of Allowed Charges, after Deductible. Percentage Coinsurance Out-of-Pocket limit applies once Spell of Illness maximum is met.

Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary.

Non-Medically Necessary private room charges that are more than the Covered Average Semi-Private Room Rate will be allowed at 80% of the Allowed Charges (up to $10 per day), after Deductible. Percentage Coinsurance Out-of-Pocket limit applies.</td><td colspan="2">Precertification required.
100% of Allowed Charges, after $131 per Continuous Confinement Inpatient Benefit Copayment. Limited to 365-benefit days per Spell of Illness. Deductible does not apply to Out-of-Network Allowed Charges.

Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary. You will be responsible for payment of charges that are more than the facility Average Semi-Private Room Rate if the private room is not found to be Medically Necessary.

If transferred from one Inpatient Hospital/facility to another Inpatient Hospital/facility only one Benefit Copayment will apply.</td></tr>
<tr><td>Inpatient Substance Use Disorder Detoxification

Inpatient rehabilitation Services Covered separately.</td><td colspan="3">Detoxification is covered on the same basis as Acute Care General Hospitals Medical Surgical care shown above.</td></tr>
</table>

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.		
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Inpatient Substance Use Disorder Rehabilitation • Hospital or Substance Use Disorder Facility Program • Partial Hospitalization **Two Partial Hospitalization days count as one Hospitalization day**	**Precertification suggested.** 100% of Allowed Charges, limited to 365 benefit days per Spell of Illness. Deductible does not apply. Additional benefits available at 80% of Allowed Charges, after Deductible. Percentage Coinsurance Out-of-Pocket limit applies once Spell of Illness maximum is met. Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary. Non-Medically Necessary private room charges that are more than the Covered Average Semi-Private Room Rate will be allowed at 80% of the Allowed Charges (up to $10 per day), after Deductible, Percentage Coinsurance Out-of-Pocket limit applies.	**Precertification required.** 100% of Allowed Charges, after $131 per Continuous Confinement Inpatient Benefit Copayment. Limited to 365-benefit days per Spell of Illness. Deductible does not apply to Out-of-Network Allowed Charges. Private room charges are limited to Average Semi-Private Room Rate unless private room is ordered by the attending Physician and found Medically Necessary. You will be responsible for payment of charges that are more than the facility Average Semi-Private Room Rate if the private room is not found to be Medically Necessary. If transferred from one Inpatient Hospital/facility to another Inpatient Hospital/facility only one Benefit Copayment will apply.	

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.			
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Hospital Outpatient Care Services	**Charges must be billed by the Hospital for its Services and Supplies. Physician charges are considered separately. Copayment (if applicable) shown below is paid per Covered Person for each Provider per service date. Copayments (if applicable) do not apply if the patient is admitted to the same Hospital from the Outpatient department.**		
Preadmission Testing (facility charge)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after $36 Benefit Copayment.	100% of Allowed Charges after $36 Benefit Copayment. Deductible does not apply.
	Benefits are available for pre-admission testing by a Hospital when all the following conditions are met: **(1)** The surgeon, as a preliminary requirement, orders the tests before you or your Dependent's admission as a registered bed patient for Surgery in a Hospital; **(2)** Tests must be consistent with the diagnosis and treatment of the condition for which the Surgery is needed; **(3)** The reservation for the Hospital bed and operating room was made before testing was done; **(4)** The patient must be physically present at the Hospital for needed tests; and **(5)** Surgery must be scheduled to take place within seven days after the tests are given. Separate charges for the emergency or Outpatient room are not Covered unless found Medically Necessary for treatment of Illness or Injury. Repeat preadmission testing is not Covered unless the prior planned admission or Surgery is deferred solely due to a change in the Covered Person's health.		
Emergency Room and Related Services Medical Emergency (facility charge)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after $68 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Emergency Room and Related Services Non-Medical Emergency (facility charge)	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after $68 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Surgery (facility charge, includes operating room and related Services or Supplies)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Radiation Therapy (facility charge)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Please refer to "Radiation Therapy" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.			
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Chemotherapy (facility charge)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Please refer to "Chemotherapy" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.		
Kidney Dialysis (facility charge)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after $36 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Please refer to "Kidney Dialysis" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.		
Physical Therapy (facility charge)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after $36 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Please refer to "Physical Therapy" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.		
Respiratory/ Inhalation Therapy (facility charge)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after $36 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Please refer to "Respiratory/Inhalation Therapy" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.		
Speech Therapy, Occupational Therapy, Cardiac Rehabilitation (facility charge)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit. Please refer to Speech Therapy, Occupational Therapy and Cardiac Rehabilitation in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.	100% of Allowed Charges after $36 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
		Limited to: 80 visits maximum per Covered Person per Calendar Year for Services rendered in an Outpatient Hospital, clinic, facility or office for speech therapy, occupational therapy and cardiac rehabilitation visits combined. Please refer to Speech Therapy, Occupational Therapy and Cardiac Rehabilitation in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.	
Diagnostic X-ray , Lab, and Machine Tests (facility charge)	100% of Allowed Charges. Deductible does not apply. Lab Interpretations and Allergy Care excluded, see separate benefits below.	**Diagnostic X-ray and Machine Tests:** 100% of Allowed Charges after $36 Network Copayment. **Diagnostic Labs:** 100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.			
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Laboratory Interpretation (facility charge)	100% of the first $35 of Allowed Charges per Illness or Injury. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies. Please refer to "Laboratory Interpretation" in the section titled "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Allergy Care (facility charge)	100% of the first $80 of Allowed Charges for all allergy Services combined per Covered Person per Calendar Year. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies. Please refer to "Allergy Care" in the section "Medical Surgical Services and Supplies" shown later in this document for Coverage criteria.	This is not a separate benefit. Benefits are available for allergy care to the same extent as any other medical condition.	
Hospital Outpatient Clinic Visit (facility charge)	100% of the first $8 of Allowed Charges per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies. Allergy Care visits excluded, see separate benefit above.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Other Outpatient Hospital Services and Supplies	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after $36 Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

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<tr><td rowspan="3">Hospital and other Facility Expense Benefits</td><td>Traditional Option</td><td colspan="2">Provider Choice Option</td></tr>
<tr><td>(POMCO/PHCS/MultiPlan)</td><td>In-Network Benefits (POMCO/PHCS/MultiPlan)</td><td>Out-of-Network Benefits</td></tr>
<tr><td colspan="3">Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.</td></tr>
<tr><td rowspan="2">Ambulance</td><td>100% of the first $50 of Allowed Charges per trip for emergency transportation to the nearest Hospital or for an approved Inpatient facility transfer. Deductible does not apply.

Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.</td><td>100% of Allowed Charges.

Coverage is limited to emergency transportation to the nearest Hospital or for an approved Inpatient facility transfer.</td><td>80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

Coverage is limited to emergency transportation to the nearest Hospital or for an approved Inpatient facility transfer.</td></tr>
<tr><td colspan="3">Air and sea ambulance may be considered only when the patient's condition was so serious the patient could not be transported safely by land ambulance or the location was inaccessible by land ambulance. Coverage will be provided for ambulance transportation to a local Hospital when ordered by a police officer, firefighter or Physician, even if found later that transportation was not Medically Necessary.
No other types of transportation or travel are Covered, whatever the reason.
Ambulance service must normally bill for Services.</td></tr>
<tr><td rowspan="2">Ambulatory Surgical Center
(facility charge)</td><td>100% of Allowed Charges. Deductible does not apply.</td><td>100% of Allowed Charges.</td><td>80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.</td></tr>
<tr><td colspan="3">Includes Services or Supplies related to Covered Surgery given and billed by the Ambulatory Surgical Center and preadmission testing within 7 days before scheduled Covered Surgery in the same facility. Services must be done by employees of the facility. Charges by the surgeons or anesthesiologists are considered separately.</td></tr>
</table>

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.			
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Inpatient Skilled Nursing Facility (SNF)/Rehabilitation Facility Care (facility charge)	**Precertification suggested.** 100% of Allowed Charges, limited to 100 benefit days per Spell of Illness. Deductible does not apply.	**Precertification required.** 100% of Allowed Charges, after $131 per Continuous Confinement Inpatient Benefit Copayment. Limited to 60 days per Spell of Illness.	**Precertification required.** 100% of Allowed Charges, after $131 per Continuous Confinement Inpatient Benefit Copayment. Deductible does not apply. Limited to 45 days per Spell of Illness.
		The limit for Inpatient SNF care is cumulative for In-Network and Out-of-Network Inpatient stays. In no event will the Plan pay more than 60 days per Spell of Illness. For example, if 45 days were paid for an In-Network facility, the 45 day limit for the Out-of-Network facility would be considered met. If 10 days were paid for Out-of-Network service, then only 50 days would be available under the In-Network benefit for the same Spell of Illness.	
	SNF admission must follow a Hospitalization of at least three days for the same Illness and start within 14 days of the Hospital discharge date. SNF days count towards 365-day Medical/Surgical/Maternity Spell of Illness limit. Once the Spell of Illness or SNF benefit day limits has been paid, no further SNF days will be paid until a new Spell of Illness has been established. Then the SNF rules for Inpatient Hospital stay and discharge apply.		
Outpatient Skilled Nursing Facility/ Rehabilitation Facility Care (SNF) (facility charge)	**Per service type:** Please refer to the specific service rendered in the section titled "Medical Surgical Services and Supplies" found later in this document for Coverage criteria and limits.		
Home Health Care (HHC) Agency Service and Supplies <u>One HHC visit equals:</u> Up to four hours of home health aid care; or each visit by other Covered members of the HHC team.	**Precertification suggested.** 100% of Allowed Charges, limited to 40 visits per Calendar Year. Deductible does not apply.	**Precertification required.** 100% of Allowed Charges. Limited to 80 visits per Calendar Year.	**Precertification required.** 80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit. Limited to 45 visits per Calendar Year.
		The limit for HHC is cumulative for In-Network and Out-of-Network Services. In no event will the Plan pay more than 80 days per Covered Person per Calendar Year. For example, if 45 days were paid for an In-Network Provider, the 45 day limit for the Out-of-Network Provider would be considered met. If 10 days were paid for Out-of-Network service, then only 70 days would be available under the In-Network benefit for the same Calendar Year.	

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Hospital and Other Facilities, Plan Exclusions, and Definitions.			
Hospital and other Facility Expense Benefits	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Hospice Care Agency	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Limited to: 210 consecutive calendar days for an Approved Plan of Care. Bereavement counseling visits limited to five visits for Covered Family Members before or up to 12 months after the Covered Person's death.		
Urgent Care Facility- Medical Emergency	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Urgent Care Facility- Non-Medical Emergency	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Surgical Charge Benefits (Physicians fees)	Refer to "Surgical Charge Benefits" shown in the section titled "Medical Surgical Services and Supplies" shown later in this document for specific Coverage criteria. Scheduled Surgical Allowance maximum of $1,500 for any combination of surgical procedures during the same operation. Covered secondary surgical procedures are allowed at 50% of the scheduled surgical allowance.	Refer to the following for Physicians Surgical benefits.	
• **Surgical Charge Benefits Outpatient Surgery**	**Specified Surgical Procedures:** 100% of Allowed Charges. Deductible does not apply. **Other Surgical Procedures:** 100% of Allowed Charges up to the Scheduled Surgical Allowance. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
• **Surgical Charge Benefits Inpatient Surgery**	**Specified Surgical Procedures :** • **Confinement not Medically Necessary**: 80% of Allowed Charges subject to Deductible and Out-of-Pocket limit. • **Confinement Medically Necessary:** 100% of Allowed Charges up to the Scheduled Surgical Allowance. Deductible amount does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies. **Other Surgical Procedures:** 100% of Allowed Charges up to the Scheduled Surgical Allowance. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Assistant Surgeon	100% of Allowed Charges up to 20% of Scheduled Surgical Allowance paid for the corresponding Covered primary surgeon's surgical procedure. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Anesthesia	**Specified Surgical Procedures Rendered in an Outpatient Setting:** 100% of Allowed Charges. Deductible does not apply. **Specified Surgical Procedures Rendered in an Inpatient Setting and Confinement not Medically Necessary:** 80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit. **Other Surgical Procedures and Specified Surgical Procedures Rendered in an Inpatient Setting and Confinement Medically Necessary:** 100% of Allowed Charges up to the Scheduled Surgical Allowance paid for primary surgical procedure for the Covered Surgery. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Transplants	**Per service type:** Please refer to “Transplants” in the section titled “Medical Surgical Services and Supplies” shown later in this document for Coverage criteria.		
Voluntary or Elective Sterilization	**Per service type:** Coverage is available for you and your eligible Spouse. Dependent children Coverage is not available. Sterilization reversal procedures are excluded.		
Bariatric Surgery	**Per service type.** Medically Necessary bariatric Surgery is Covered. Bariatric Surgery reversals are excluded.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
In-Hospital/Facility Physician's Care	100% of the first $25 of Allowed Charges per day for days 1-59 and $10 for days 60-365 per Spell of Illness. Deductible does not apply. Balance of Allowed Charges, Covered visits over the 365-day Spell of Illness Limit, or Covered visits over one per day are payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Benefits are available for Inpatient Physician visits (excluding surgeon, assistant surgeon, anesthesiologist or obstetrical postoperative care) in a Hospital, Skilled Nursing Facility or a Covered facility for Mental Disorder care. Coverage is only provided for visits for days approved for a Covered Inpatient stay. Substance Use Disorder Inpatient rehabilitation visits are not Covered under this benefit.		
Inpatient Consultation	100% of the first $50 of Allowed Charges per Confinement, per specialty. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies. Additional consultations for the same specialty per Confinement are payable at 80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Outpatient Consultation	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Second Opinion Consultation			
• **Obtained through the Cost Management Program**	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
• **Not obtained through the Cost Management Program**	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Second Opinion Consultation for Cancer Diagnosis	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
	This consultation benefit includes consultation, exam, written report and related tests. When second medical opinion consultations for cancer by an Out-of-Network Provider is pursuant to a written Physician referral, benefits will be provided at the Network level of benefits, at no additional cost to the Enrollee beyond what such person would have had to pay a Network Provider.		
Outpatient Provider Care	Services must be given and billed by a Covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Consultations, surgical and obstetrical procedures, emergency room, Mental Disorder care, and Substance Use Disorder care are not Covered under this benefit.		
• **Office, clinic or Urgent Care Facility** (non-Medical Emergency)	100% of the first $8 of Allowed Charges per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
• **Home** (non-Medical Emergency)	100% of the first $10 of Allowed Charges per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
• **Medical Emergency Care in the home, office, clinic or Urgent Care Facility**	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Foot Care and Podiatry Services	**Per service type:** Please refer to "Foot Care and Podiatry Services" found in the section titled "Medical Surgical Services and Supplies" found later in this document for Coverage criteria.		
Emergency Room Visit- Medical Emergency (Physician's charge)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Emergency Room visit- Non-Medical Emergency (Physician's charge)	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Diagnostic X-ray and Machine Testing (includes professional interpretation charges)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Laboratory Tests (excluding allergy testing)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Laboratory Professional Interpretation Charges	100% of the first $35 of Allowed Charges per Illness or Injury. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Kidney Dialysis Home, Office or Medicare Certified Dialysis Center (Includes procedures and related Supplies)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician charges for medical management are Covered separately as Physician visits.		
Allergy Care (office visits, testing, allergy injections, allergy serum, and therapies)	100% of the first $80 of Allowed Charges for all allergy Services combined per Covered Person per Calendar Year. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	**Testing, Injections, Serums and Therapies:** 100% of Allowed Charges. **Office Visits:** 100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Radiation Therapy (includes procedures and related Supplies)	100% of Allowed Charges. Deductible does not apply.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician charges for evaluation and management Services are Covered separately as Physician visits.		
Chemotherapy (includes infusion procedures and related Supplies)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician charges for evaluation and management Services are Covered separately as Physician visits.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Outpatient Treatment for Mental Disorders	100% of the first $8 of Allowed Charges, per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Coverage is limited to Medically Necessary visits. Coverage will be provided separately for a Medically Necessary individual and a group therapy visit given on the same day. Services must be rendered and billed by a New York State (NYS) licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of NYS the Provider must be operating within the scope of their license; and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation or clinic for the services of a similarly licensed Provider will also be Covered.		
Outpatient Treatment for Substance Use Disorder	100% of the first $8 of Allowed Charges, per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Medically Necessary family counseling for Family Members will be Covered.		
Inpatient and or Outpatient Private Duty Nursing or Personal Nursing Care	Not a benefit unless part of HHC, Hospice, Benefit Management Assessment or Case Management Program.		
Physical Therapy	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges subject to Deductible and Out-of-Pocket limit.
		Pre-approval of Services required after 15 visits.	
	Therapy must be needed to significantly and measurably restore body function lost due to Illness or Injury. Maintenance Care is not Covered. **Physician's prescription required.**		
Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit. Maintenance Care is not Covered. **Physician's prescription required.**	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
		Limited to: 80 visits maximum per Covered Person per Calendar Year for Services rendered in an Outpatient Hospital, clinic, facility or office for speech therapy, occupational therapy and cardiac rehabilitation visits combined. Maintenance Care is not Covered. **Physician's prescription required.**	

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Respiratory/ Inhalation Therapy	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Maintenance Care is not Covered. **Physician's prescription required.**		
Durable Medical Equipment (DME)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician's prescription required. Coverage includes necessary Supplies to operate the DME. Duplicate equipment or delivery charges are not Covered. Specialized equipment is excluded when standard equipment is adequate for the patient's condition.		
Prosthetics/ Orthotics	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician's prescription required. Prosthetic devices or Orthotics must replace physical organs or parts, or aid in their function. Replacement will only be considered for Coverage when needed due to a change in the patient's body condition. Specialized equipment is excluded when standard equipment is adequate for the patient's condition. Specifically excluded are foot orthotics or other foot devices used for misalignment of the feet, routine foot care, or for athletic use and wigs.		
Oxygen	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Physician's prescription required. Medically Necessary home self-care oxygen and Supplies are Covered.		
Medical/Surgical Supplies (home use)	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Therapeutic Injections in an Outpatient Physician's Office Setting	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Blood Services	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Autologous (self blood donation) or directed donation (i.e. by parent for minor child) blood donations before scheduled Surgery that usually requires blood transfusions are Covered when found Medically Necessary.		

The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.			
Medical/Surgical Services and Supplies	**Traditional Option**	**Provider Choice Option**	
	(POMCO/PHCS/MultiPlan)	**In-Network Benefits (POMCO/PHCS/MultiPlan)**	**Out-of-Network Benefits**
	Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.		
Contact Lens or Eyeglasses Following Intraocular or Cataract Surgery	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Limited to: initial pair of eyeglasses or contact lenses and exam.		
Limited Dental Care	**Per service type rendered.** Medical Expense benefits limited to: **(1)** The diagnosis and treatment of oral tumors and cysts. **(2)** Treatment of Injury to Sound Natural Teeth or the jaw that is rendered within 12 months of the Injury, including all related care, Supplies and Prosthetics. **(3)** Services or Supplies connected with treatment due to congenital disease or anomaly. **(4)** Medically Necessary Services for care and treatment of Temporomandibular Joint Syndrome excluding appliances and adjustments or Supplies for appliances.		
Hearing Aid(s)			
• **Due to hearing loss following a surgical procedure**	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Limited to: Initial hearing aid(s) that are required due to hearing loss resulting from a surgical procedure performed while the Covered Person was eligible and enrolled		
• **Other Medically Necessary Hearing Aid(s)**	Not a benefit.	100% of Allowed Charges.	**Hearing aid:** 100% of Allowed Charges, subject to Deductible. **Exam and fitting:** 80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
	Limited to $1,000 per ear paid benefit maximum per Covered Person once every five Calendar Years for the hearing aid. Related exam and fitting is also allowed, and does not apply to the $1,000. per ear paid benefit limit.		
Diabetic Supplies/Equipment	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.
Diabetic Education	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.	100% of Allowed Charges after Network Copayment.	80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.

<table>
<tr><td colspan="4">The following Summary of Benefits is a brief outline of the special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service, please refer to Medical/Surgical Services and Supplies, Plan Exclusions, and Definitions.</td></tr>
<tr><td rowspan="3">Medical/Surgical Services and Supplies</td><td>Traditional Option</td><td colspan="2">Provider Choice Option</td></tr>
<tr><td>(POMCO/PHCS/MultiPlan)</td><td>In-Network Benefits (POMCO/PHCS/MultiPlan)</td><td>Out-of-Network Benefits</td></tr>
<tr><td colspan="3">Unless specifically noted benefit limits are cumulative for In-Network and Out-of-Network Services combined.</td></tr>
<tr><td rowspan="2">Chiropractic Care</td><td>Office visit: 100% of the first $8 of Allowed Charges per visit. Deductible does not apply. Balance of Allowed Charges payable at 80%, after Deductible. Out-of-Pocket limit applies.

Other services: 80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.</td><td>100% of Allowed Charges after Network Copayment.</td><td>80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.</td></tr>
<tr><td colspan="3">Maintenance Care is excluded.</td></tr>
<tr><td>Infertility</td><td colspan="3">Per service type rendered. Benefits are available for Services or Supplies related to the treatment of Infertility for Covered Persons, ages 21-44 years old (or any age for diagnosis and treatment of correctable medical condition otherwise Covered by the Plan that results in Infertility).</td></tr>
<tr><td>Psoralen & Ultraviolet Radiation Light Therapy (PUVA)</td><td>80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.</td><td>100% of Allowed Charges.</td><td>80% of Allowed Charges, subject to Deductible and Out-of-Pocket limit.</td></tr>
<tr><td>Pharmacy Benefit
• This Plan is Primary</td><td colspan="3">Benefits are only available through CVS/Caremark under Prescription Drug Benefits; not Medical Benefits.</td></tr>
<tr><td>• This Plan is Secondary</td><td colspan="3">Benefits are not available through CVS/Caremark. Benefits are available under Medical Benefits. 100% of Allowed Charges minus applicable Prescription Drug Copayment. Deductible, and Percentage Coinsurance Out-of-Pocket limit does not apply.

All benefit limitations and exclusions apply as noted in the Prescription Drug Benefits portion of the Plan. Plan benefits are coordinated with the primary plan’s benefits.</td></tr>
</table>

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are separate from Medical Benefits and do not apply to the Deductibles, Copayments or Out-of-Pocket limits for Medical Benefits.

You and your Dependents may purchase drugs from any Pharmacy. However, if this Plan is considered the primary payer and you or your Covered Dependent choose a CVS/Caremark Network Pharmacy or use the CVS/Caremark Mail Order Pharmacy for maintenance drugs, you save costs for yourself and the Plan. Pharmacy Benefits are separate from Medical Benefits and do not count towards the medical Deductible or Out-of-Pocket limit.

When this Plan is primary: Prescription Drug Services are paid through the Claims Administrator (CVS/Caremark) for Prescription Drug Benefits.

When this Plan is secondary: If another plan is considered primary Coverage for Prescription Drugs, Plan benefits will coordinate under the COB provisions of this Plan. Plan Benefits will be administered by POMCO; not CVS/Caremark. Refer to Medical Benefits above for benefit information. If this Plan is secondary, do not show your Jefferson Lewis et al. Schools Employee Healthcare Plan identification card at the time of purchase. Claims should first be submitted to the primary plan, and then you may obtain a POMCO claim form from your Participating School healthcare clerk or from POMCO. Complete the claim form and attach your original Prescription Drug receipt (receipt should include dates of purchase, name of drug, dose and RX #) and a copy of the primary plan's explanation of benefits and mail to:

POMCO
P.O. Box 6329
Syracuse, NY 13217

Allowed Charge(s) is the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered Pharmacy Services rendered and billed by a Covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network negotiated rates. The Enrollee is responsible for payment of any charges that are not allowed under the Plan and or any applicable Copayments, and if an Out-of-Network Pharmacy is used, the Covered Person is responsible for the payment of charges more than the Usual, Reasonable, and Customary Allowed Charges.

A **Copayment** is a smaller amount of money that is applied to each Covered Pharmacy drug or mail order drug charge and is shown in the "Schedule of Benefits". The Copayment amount is not a Covered Charge under the Medical Plan. Any one retail Pharmacy prescription is limited to a 34-day supply. Any one mail order Pharmacy prescription is limited to a 90-day supply. You are responsible for the Copayment amount as shown in the "Schedule of Benefits" for Covered prescription medications and Supplies.

When two or more prescriptions or refills are dispensed at the same time, a Copayment must be paid for each prescription order or refill. When a treatment regimen contains more than one type of drug and the drugs are packaged together for the convenience of the Covered Person, a Copayment will apply to each type of drug.

INDEXING- Provider Choice Option only

The Copayments are subject to change based on the aggregate increase or decrease in the cost of providing the health benefits under the Plan and a determination by the Plan Administrator. In making this determination, the Plan Administrator will take into account: The past Calendar Year Plan experience, the inflation index; the northeast medical component of the U.S. Consumer Price Index (CPI); and trends in the healthcare industry. Any such changes will be effective the following July 1. You will be notified before the effective date of any changes.

The following Summary of Benefits is a brief outline of the benefits payable under the Plan. For a more detailed description of Covered services, please refer to the section(s) entitled Prescription Drug Benefits, Plan Exclusions, and Definitions.

Covered Drugs and Supplies	**Network and Out-of-Network Pharmacy**	
	Traditional Option	**Provider Choice Option**
Retail Pharmacy (up to 34-day supply) **Copayment amounts:** • **Generic Drug** • **Preferred Brand Name Drug** • **Non-Preferred Brand Name Drug**	$17 per prescription or supply $30 per prescription or supply $55 per prescription or supply	$17 per prescription or supply $30 per prescription or supply $55 per prescription or supply
* **Mail Order Pharmacy** (up to 90-day supply) **Copayment amounts:** • **Generic Drug** • **Preferred Brand Name Drug** • **Non-Preferred Brand Name Drug**	$30 per prescription or supply $55 per prescription or supply $80 per prescription or supply	$30 per prescription or supply $55 per prescription or supply $80 per prescription or supply
* A 30-day supply of the prescription for a new RX (drug) must be first purchased at a retail Pharmacy before a mail order Pharmacy order can be submitted.		
Smoking Cessation Program: Limited to 90 days of prescription cessation aids per Covered Person's Lifetime when purchased through the Pharmacy Benefit Program. Subject to Pharmacy Program Copayments.		
Benefit includes state mandated prescription contraceptives for birth control and Prescription Drugs for the treatment of Infertility. Coverage is provided for FDA approved cancer drugs even when prescribed for a cancer diagnosis not specifically approved by the FDA for that drug unless the FDA has determined that the drug is contraindicated for the treatment of that type of cancer. See additional requirements for Coverage under "Prescription Drug Benefits" later in this document. In addition to Prescription Drugs, Coverage is provided for Covered diabetic Supplies, aminoacidopathies formula or enteral formulas and modified food products. (Allowed Charges for modified food products is limited to $2,500 per Covered Person per Calendar Year.)		

VISION CARE BENEFITS (Provider Choice Option only)

Vision Care Benefits are available for routine vision Services only. These claims are administered by the Vision Care Claims Administrator, Davis Vision. Vision Care Benefits are separate from Medical Benefits and do not count towards the Medical Deductible, or Out-of-Pocket limit. Benefits are limited to once every two Calendar Years for each Covered Person.

In-Network Benefits. You are only responsible for the Copayment, if any, for Plan selection. You are responsible for any additional costs for any choices outside of the Plan selection.

A **Copayment** is a smaller amount of money that is applied to each Covered Vision Care charge and is shown in the "Schedule of Benefits". The Copayment amount is not a Covered Charge under the Medical Plan. You are responsible for the Copayment amount as shown in the "Schedule of Benefits" for Covered Vision Care Services and Supplies.

Out-of-Network Benefits. Payments for Out-of-Network Services are limited to the scheduled allowances shown. You are responsible for the payment of any balance.

INDEXING

The Copayments and Out-of-Network allowances are subject to change based on the aggregate increase or decrease in the cost of providing the health benefits under the Plan and a determination by the Plan Administrator. In making this determination, the Plan Administrator will take into account: The past Calendar Year Plan experience, the inflation index; the northeast medical component of the U.S. Consumer Price Index (CPI); and trends in the healthcare industry. Any such changes will be effective the following July 1. You will be notified before the effective date of any changes.

Vision Care Covered Services	In-Network	Out-of-Network
Eye Exam	$24 Copayment	Maximum payment $51
Lenses (per pair)	100% of Network benefits for Plan selection lenses. Additional costs paid by you for lenses not in the Plan selection.	Maximum payment: Single vision $41 Bifocal $58 Trifocal $75
Frames	100% of Network benefits for Plan selection frames. Additional costs paid by you for frames not in the Plan selection.	Maximum payment $51
Contact Lenses (in lieu of glasses)	**Standard, soft daily wear:** $44 Copayment for Plan selection. Additional costs paid by you for contacts not in the Plan selection. **Disposable lenses in lieu of standard wear lenses:** $76 Copayment for the initial supply of Plan selection. Additional costs paid by you for disposable lenses not included in the Plan selection.	Maximum payment $126
Benefit is limited to one pair of glasses (lenses and/or frames) or contact lenses every two Calendar Years per Covered Person, not both.		

COST MANAGEMENT SERVICES

This Cost Management program does not apply if your primary Coverage is Medicare or another group health benefit plan.

The Cost Management program is designed to answer questions and explore your choices when you or your Covered Dependents face Hospitalization, Surgery or extensive medical care. The POMCO professional staff evaluates the medical facts and advises you whether Coverage is available (preauthorization). If an Inpatient stay or treatment is not preauthorized, you or your Dependents may still choose to enter an Inpatient facility or to have the treatment. However, the Plan may not make payment if the stay or treatment is not Covered according to Plan provisions in effect at the time Services are Incurred. If a claim is denied based on determination of not Medically Necessary or considered Investigational, you may seek an internal appeal and external appeal as shown in the section entitled "Claims Appeal Procedure" shown later in this document.

Precertification or preauthorization 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 based entirely on the limited information provided to the POMCO Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether Services are Covered according to Plan limitations and exclusions in force at the time Services are rendered.

Cost Management Services Phone Number

POMCO
1-888-201-5150

Please refer to the Employee ID card for the Cost Management Services phone number. This number is a 24-hour service. If you wish to talk to the POMCO nurses, you must call between 8:00 A.M. and 6:00 P.M. E.S.T. on normal business days (Monday – Friday). Otherwise, provide complete information as requested by voice mail message.

HOW THE PROGRAM WORKS

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Precertification of the Medical Necessity for the following non-emergency Services before medical and/or surgical Services are provided:

Hospitalizations
Substance Use Disorder/Mental Disorder Inpatient admissions
Skilled Nursing Facility stays
Home Health Care

(2) Medical Procedure Review (Provider Choice Option only)

Dilatation and Curettage (D & C unrelated to Pregnancy)
Weight reduction surgical procedures
Knee joint repair/replacement
MRA (magnetic resonance angiography)
MRI (magnetic resonance imaging)
PET scans
Varicose vein Surgery

(3) Prospective Procedure and Plan Review (Traditional Option only)

Oxygen and oxygen equipment
Rehabilitative Services (cardiac, physical, occupational or speech therapy)
Rental/purchase of Durable Medical Equipment
Outpatient Surgery
Kidney Dialysis

(4) Retrospective review of the Medical Necessity of the listed Services provided on an emergency basis;

(5) Concurrent review, based on the admitting diagnosis, of the listed Services requested by the attending Physician; and

(6) Certification of Services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

PRECERTIFICATION

(1) Traditional Option: This phone call is voluntary. The patient or family member should call this number to receive certification of certain Cost Management Services.

(2) Provider Choice Option: The patient or family member must call this number to receive certification of certain Cost Management Services.

Noncompliance Benefit Reduction (Provider Choice Option only). Failure to follow this procedure may reduce reimbursement received from the Plan. If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50% up to a maximum of $250.00.

Any reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum Out-of-Pocket limit.

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical Services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 days before** Services are

scheduled to be rendered with the following information:

- The name of the patient and relationship to the Covered Employee
- The name, Member ID number and address of the Covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of Surgery
- The proposed rendering of listed medical Services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission **or as soon as reasonably possible** .

The patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 24 hours or as soon as reasonably possible** following Inpatient stays of **48 hours after normal delivery** or **within 96 hours or as soon as reasonably possible** after **caesarian delivery.**

The patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 24 hours or as soon as reasonably possible** following Inpatient stays of 96 hours **for Newborns**.

The patient, patient's family member, or attending Physician must contact the utilization review administrator before home care begins when the Physician decides that you or your Covered Dependents require Home Health Care Services instead of Confinement.

The utilization review administrator will determine the number of days of Medical Care Facility Confinement or use of other listed medical Services authorized for payment.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical Services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical Services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional Services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional Services or days. Please refer to "Utilization Review" shown later in this section for additional details.

MEDICAL PROCEDURE REVIEW – SECOND OPINION PROGRAM (Provider Choice Option only)

Certain medical, diagnostic, or surgical procedures are performed either inappropriately or unnecessarily. If this Plan is primary, you are encouraged to call POMCO when you or your Dependents are scheduled for one of the listed procedures.

In some cases, Surgery or a specific procedure is only one of several treatment options. In other cases, Surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the voluntary second opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

Benefits will be provided for a second opinion consultation to determine the Medical Necessity of an elective surgical procedure or medical or diagnostic procedure.

As patterns of medical practice change, the specific procedures for which a second opinion is recommended also change. All Covered Persons can receive a list of procedures for which a second opinion is recommended. Please contact the Plan Administrator or the utilization review administrator for this list.

Before a Covered Person has a Surgery or procedure performed that is on the list, the Covered Person should contact the utilization review administrator at:

POMCO
1-888-201-5150

The number listed on the Employee's ID card to receive information on how to obtain a second opinion or to confirm the need for the Surgery or a procedure. Your phone call will start the medical review process. POMCO will mail its determination to you within two business days after their evaluation.

These additional consultations must be performed by Physicians who are:

(1) Board Certified Specialists in the area in the appropriate field of medicine for which the patient is contemplating Surgery, or other procedure; and

(2) Is not financially associated with the surgeon who originally recommended the Surgery or procedure.

If you obtain a Second Opinion Consultation (SOC) through the Cost Management program from an In-Network Provider, Covered Services are payable at 100% of Allowed Charges by the Plan. Network Copayments will not apply. If you obtain the SOC from an Out-of-Network Provider, Covered Services are payable at 100% of Allowed Charges by the Plan. Deductible will not apply.

After the SOC, it is up to you or your Covered Dependent whether to proceed with the procedure. If the procedure is done, usual Plan limitations and exclusions apply to the procedure expenses. However, if this SOC specialist does the procedure, Plan benefits will not be paid for the SOC. This review does not guarantee benefits to you or the Provider and will not result in payment that would not otherwise be payable.

PROSPECTIVE PROCEDURE AND PLAN REVIEW (Traditional Option only)

Certain medical procedures, or treatment Plans are performed either inappropriately or unnecessarily. If this Plan is primary, you are encouraged to call POMCO when you or your Dependents are scheduled for one of the listed procedures.

The POMCO professional staff will assist you in making decisions concerning your options and Plan Coverage for these Services. The POMCO professional staff will work with you and your doctor to use Services Covered by the Plan. If in doubt on any procedure or treatment, call anyway. This review does not guarantee benefits to you or the Provider and will not result in payment that would otherwise be payable.

CASE MANAGEMENT

The Plan may elect, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management", shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and Services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment Plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment Plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment Plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment Plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

This Program does not guarantee benefits to you or to the Provider and will not result in payment that would not otherwise be payable.

UTILIZATION REVIEW

The Plan has mandatory and voluntary phone call requirements as shown previously in this section.

Utilization review (UR) decisions related to the Medical Necessity of care, including the appropriateness of the level of care or the Provider of care; or to the Experimental and/or Investigational nature of the care. UR decisions are made when prior authorization is requested for care (‘the prospective review process”, during the course of care (the “concurrent review process”), and after care is rendered (the “retrospective review process”).

Examples of cases that would be reviewed under the UR procedure include our refusal of prior authorization for cases determined not to be Medically Necessary based on Plan language; or our determination that the treatment is Investigational, in light of your condition.

The steps of UR procedures are as follows:

(1) Prior Authorization Process/Prospective Review. All requests for prior authorization of care are reviewed for Medical Necessity (including the appropriateness of the proposed level of care and/or Provider). A POMCO nurse performs the initial review. If the nurse determines that the proposed care is Medically Necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not Medically Necessary or that further evaluation is needed, the nurse will refer the case to a licensed Physician.

(2) Concurrent Reviews. When you or your Covered Dependent are receiving Services that are subject to concurrent review, a POMCO nurse will periodically assess the Medical Necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a

POMCO nurse will determine whether the Services are Medically Necessary. If so, the nurse will authorize the care. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed Physician.

Utilization review decisions for Services during the course of care (concurrent review) will be made and notice provided to the Provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision.

If care is authorized, the notice will identify the number of approved Services, the new total of approved Services, the date service may begin, and the date of the next scheduled concurrent review of the case.

(3) Retrospective Reviews. A POMCO nurse may review retrospectively the Medical Necessity of claims that are subject to utilization review. If the nurse determines that care you or your Dependents received was Medically Necessary, the nurse will authorize benefits. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed Physician.

Utilization review decisions for Services that have already been received (retrospective review) will be made, and notice provided to you or your Covered Dependent and the Provider, in writing, within 30 business days of receipt of information necessary to make a decision.

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness and while the person is Covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the Deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum Out-of-Pocket limit.

Individual Deductible Three Month Carryover- Traditional Option only. Covered Charges Incurred in, and applied toward the individual Deductible in October, November and December will be applied toward the individual Deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident- Traditional Option only. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate Deductibles for treatment of Injuries Incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Payment will be made at the rate shown under reimbursement rate in the “Schedule of Benefits”. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown in the “Schedule of Benefits” each Calendar Year until the Out-of-Pocket limit shown in the “Schedule of Benefits” is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% of Allowed Charges (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% of Allowed Charges (except for the charges excluded) for the rest of the Calendar Year.

OUT OF COUNTRY CARE

This Plan will provide benefits for Covered expenses Incurred outside the USA. Plan benefits will be based on the currency exchange rate in effect at the time Services are rendered. You may be required to pay the Provider at the time of Service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of Service, charge for each Service (currency of the country if not in US dollars), date(s) of Service, and name of country where Services are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the Enrollee directly.

COORDINATION OF BENEFITS

When Services and Supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the coordination of benefits provision and Medicare secondary payer rules, all benefits will still apply. Any applicable Network and Benefit Copayments are waived.

COVERED CHARGES

Covered Charges are the Allowed Charges that are Incurred for the following items of Service and Supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the Service or Supply is performed or furnished.

INDEXING-Provider Choice Option only

The Deductible and Out-of-Pocket limit (OOP) are subject to change based on the aggregate increase or decrease in the cost of providing the health benefits under the Plan and a determination by the Plan Administrator. In making this determination, the Plan Administrator will take into account: The past Calendar Year Plan experience, the inflation index; the northeast medical component of the U.S. Consumer Price Index (CPI); and trends in the healthcare industry. Any such changes will be effective the following July 1. You will be notified before the effective date of any changes.

PREVENTIVE CARE

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the "Schedule of Benefits".

Charges for Routine Well Child Care:

- **Well Newborn Nursery/Physician Care:** The benefit is limited to the Allowed Charges made by a Physician for routine pediatric care for the first four days after birth while the Newborn child is Hospital-confined.
- **Routine well child care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits, related testing and immunizations.
- Coverage for health care visits, and related testing is intended to be consistent with the clinical standards set forth by the American Academy of Pediatrics. If these standards change, the Plan will automatically cover the new recommended standards.
- Coverage for immunizations follows the recommendations of the Advisory Committee on Immunization Practices (ACIP) and/or as set forth by New York State Insurance law. If these standards change, the Plan will automatically cover the new recommended standards.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness. Benefit payment for routine well adult care is subject to the limits shown in the Schedule of Benefits.

- Routine Adult Physical Exams, to include related screening tests
- Adult Immunizations
- Routine Mammography
- Routine Gynecological Exam, and Cervical Cancer Screening
- Bone Mineral Density measurement and tests
- Routine Prostate Exam and testing

HOSPITAL AND OTHER FACILITIES

This benefit applies when a Hospital charge is Incurred for the care of a Covered Person's Injury or Sickness and during a Hospital Confinement that starts while that person is Covered for this benefit.

INPATIENT HOSPITAL CARE. Includes Services rendered in a Hospital Outpatient setting, clinic or Physician's office. The medical Services and Supplies furnished by a Hospital or a Birthing Center.

(1) Benefits for Room and Board charges. Room and Board charges are payable as described in the "Schedule of Benefits".

The Plan pays the Average Semi-Private Rate for Room and Board charges by a Hospital or other Covered Inpatient health facility. If the Inpatient facility does not have a Semi-Private Rate, the rate shall be 90% of the Room and Board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used. Semi-private accommodations are generally rooms with two or more beds.

Charges for a private room will be Covered if a private room is deemed to be Medically Necessary.

Charges for an Intensive Care Unit, Cardiac Care Unit or similar room stays are payable as described in the "Schedule of Benefits".

(2) Benefits for special charges (miscellaneous charges). The Allowed Charges for Hospital-billed medical Services and Supplies (other than Room and Board) and diagnostic X-rays and lab tests are payable. Such Services and Supplies must be Medically Necessary for the patient's treatment.

For claims that contain implant charges, the implant charges may be denied unless they are submitted with the implant invoice. The implant charges on the claim that includes the implant invoice will be paid up to 50% above the invoice amount or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary Charge.

(3) Coverage of Pregnancy. The Allowed Charges for the care and treatment of Pregnancy are Covered the same as any other Sickness.

Under federal law and New York State Insurance Law, group health Plans may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. In any case, Plans cannot require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). In addition to the Newborns' and mothers' length of stay requirements shown above, the applicable State Insurance Law mandates that Inpatient Coverage be provided for:

(a) Inpatient parent education; assistance and training in breast and bottle-feeding, performance of necessary maternal and Newborn clinical assessment.

(b) Services of a nurse-midwife licensed pursuant to Article 140 of the NYS Education Law, practicing consistent with a collaborative relationship with a Physician or with a facility licensed under Article 28 of the NYS Public Health Law. Duplicative routine Services provided by a certified nurse-midwife and a Physician will not be Covered.

(c) In addition the mother has the option to be discharged earlier than the minimum time periods stated above. In which case, Coverage will be provided for one home care visit. This Coverage will be in addition to home health care Coverage provided in the Plan. This home care visit may be requested any time within the first 48 hours of the time of delivery (96 hours in the case of cesarean section) and shall be delivered within 24 hours after discharge or at the time of the mother's request, whichever is later. No Deductibles or Copayments shall apply to this home care visit.

(4) Charges for Routine Nursery Care. Routine well Newborn nursery care is care while the Newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This Coverage is only provided if a parent is a Covered Person who was Covered under the Plan at the time of the birth and the Newborn child is an eligible Dependent and is neither injured nor ill and is enrolled in your family Coverage within 30 days after the date of birth.

The benefit is limited to Allowed Charges for nursery care for the first four days after birth while the Newborn child is Hospital confined as a result of the child's birth. After four days, continued care must be for the treatment due to Illness of the Newborn that required Inpatient Care. Additional benefits will not be paid for routine Newborn care if extended due to the mother's continued stay, even if the mother is providing personal baby care, such as breastfeeding.

INPATIENT MENTAL DISORDER CARE

Covered Charges for care, Supplies and treatment of Inpatient Mental Disorders will be covered as shown in the "Schedule of Benefits". Coverage includes Hospitals, Psychiatric Facilities, and Partial Hospitalization (two days of Partial Hospitalization equal one day of Hospitalization). Covered Charges for approved care, Supplies and treatment of Mental Disorders will be limited as follows:

(1) All treatment is subject to the benefit payment maximums shown in the "Schedule of Benefits".

(2) Medical documentation must show that the patient required the Inpatient stay due to Medical Necessity and that the course of treatment could only be given on an Inpatient basis.

You should **obtain pre-approval** from the Claims Administrator before treatment begins to be sure the facility meets the Plan requirements.

(3) Coverage for Inpatient Care also includes the following treatment.

(a) Treatment of biologically-based mental Illness for adults and children is Covered. "Biologically-based mental Illness" is defined as a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Illness (such as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia).

(b) Treatment of serious emotional disturbances in children under age 18 years is Covered, when related to attention deficit disorder, disruptive behavior disorders or pervasive development disorders and where there are one or more of the following:

(i) serious suicidal symptoms or other life-threatening self-destructive behavior;

(ii) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);

(iii) behavior caused by emotional disturbances that placed the child at risk of causing personal Injury or significant property damage; or

(iv) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Counseling or therapy primarily rendered for marital, family and sexual problems, educational services (including dysfunctional or vocational training), or Custodial Care is not Covered. Recreation and personal items are not Covered.

INPATIENT SUBSTANCE USE DISORDER CARE

Covered Charges for care, Supplies and treatment of Inpatient Substance Use Disorder will be covered as shown in the "Schedule of Benefits" for Services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) and for Partial Hospitalization (two days of Partial Hospitalization equal one day of Hospitalization) for an Approved Plan of Inpatient Care. Covered Charges for approved care, Supplies and treatment of Substance Use Disorder will be limited as follows:

(1) Inpatient detoxification is considered a medical condition eligible for General Hospital benefits. Expenses for Inpatient Substance Use Disorder (alcohol or drug abuse) rehabilitation are Covered separately from detoxification.

(2) Services or Supplies must be provided by the Covered facilities employees during an approved Inpatient stay.

You should **obtain pre-approval** from the Claims Administrator before treatment begins to be sure the facility meets the Plan requirements. Benefits are not payable for Services that consist primarily of participation in programs of a social, recreational, or companionship nature.

OUTPATIENT HOSPITAL. Services or Supplies must be provided by the Hospital and given by Employees of the Hospital. Services and Supplies payable are:

(1) Preadmission testing service. The Medical Benefits percentage payable will be for diagnostic lab tests, diagnostic machine tests and X-ray exams subject to the conditions shown in the "Schedule of Benefits".

(2) Outpatient emergency accident care, emergency medical care and non-Medical Emergency care. Allowed Charges are payable as described in the "Schedule of Benefits" for Services and Supplies found Medically Necessary according to Plan provisions.

Traditional Option. Separate charges for use of the emergency room for scheduled physical therapy, cardiac rehabilitation, chemotherapy, radiation therapy, respiratory/inhalation therapy, speech therapy or similar scheduled Services are not Covered unless found to be Medically Necessary for treatment of Illness or Injury.

Provider Choice Option. Separate charges for use of the emergency room for scheduled physical therapy, cardiac rehabilitation, chemotherapy, radiation therapy, respiratory/inhalation therapy, speech therapy or similar scheduled Services are not Covered unless records can show that other unscheduled emergency care of an Illness or Injury was given.

(a) Emergency care for the initial treatment of a traumatic bodily Injury resulting from an accident or initial treatment of a Medical Emergency as defined by the Plan as shown in the "Schedule of Benefits".

(b) Care for Medically Necessary non-Medical Emergency or Accidental Injury is payable as described in the "Schedule of Benefits".

(3) Outpatient surgical care.

(4) Outpatient therapy Services after an Injury or Illness. Allowed Charges are payable as described in the "Schedule of Benefits" for Services and Supplies found Medically Necessary according to Plan provisions for the following therapies:

(a) Radiation therapy.

(b) Chemotherapy/Infusion therapy.

(c) Dialysis in a Hospital.

(d) Physical therapy.

(e) Respiratory/Inhalation therapy.

(f) Speech therapy.

(g) Occupational therapy.

(h) Cardiac rehabilitation

Traditional Option. Separate charges for use of the emergency or Outpatient rooms are not Covered unless found to be Medically Necessary for treatment of Illness or Injury.

Provider Choice Option. Separate charges for emergency or Outpatient rooms are not Covered unless records can show that other unscheduled emergency care of an Illness or Injury was given.

(5) Outpatient diagnostic Services. Allowed Charges are payable as described in the "Schedule of Benefits" for Services and Supplies found Medically Necessary according to Plan provisions.

(a) Diagnostic radiology, ultrasound, nuclear medicine, and necessary Supplies.

(b) Laboratory and pathology.

(c) ECG, EEG, and other diagnostic medical and physiological medical testing procedures.

(6) Clinic Services or Supplies. Allowed Charges are payable as described in the "Schedule of Benefits" for Services and Supplies found Medically Necessary according to Plan provisions.

(7) Other Hospital Services or Supplies. Allowed Charges are payable as described in the "Schedule of Benefits" for Services and Supplies found Medically Necessary according to Plan provisions.

For claims that contain implant charges, the implant charges may be denied unless they are submitted with the implant invoice. The implant charges on the claim that includes the implant invoice will be paid up to 50% above the invoice amount or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary Charge.

AMBULANCE CHARGES

Benefits are available for emergency or urgent ambulance transportation to a local Hospital that can provide the necessary emergency treatment. If a local Hospital cannot provide the needed care, Coverage is available for transportation to the nearest Hospital that can provide the emergency treatment. Coverage is provided for ambulance transfer from one Inpatient facility to another local Inpatient facility when found Medically Necessary and ordered by a Physician. Such transfers cannot be for the convenience of the patient or family.

Coverage is not provided for travel or transportation of persons other than the patient, such as medical personnel, or members of the family or friends, whatever the reason.

Professional and volunteer ambulance must charge for its Services.

AMBULATORY SURGICAL CENTER, as defined, for Outpatient Surgery.

For claims that contain implant charges, the implant charges may be denied unless they are submitted with the implant invoice. The implant charges on the claim that includes the implant invoice will be paid up to 50% above the invoice amount or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary Charge.

SKILLED NURSING FACILITY/REHABILITATION FACILITY CARE (SNF)

Inpatient SNF Services. The Room and Board and nursing care furnished by a Skilled Nursing Facility must meet all of the following conditions:

(1) Confinement must follow three full days of Acute Care General Hospitalization and begin within 14 days after discharge from such Hospitalization;

(2) SNF admission must be ordered by the attending Physician and the patient must remain under the care of a Physician during the SNF Confinement;

(3) The attending Physician certifies that the Confinement is needed for further care of the condition that caused the Hospital Confinement;

(4) Care is found Medically Necessary and at the skilled level of care, according to Plan provisions. Skilled level of 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 provided for Custodial, Maintenance, nursing home or residential care;

(5) Coverage may only be provided as long as Inpatient Care in an Acute Care General Hospital would have been necessary if care in a Skilled Nursing Facility were not provided;

(6) Diagnostic and therapeutic Services must be provided and billed by the facility and given by employees of the facility.

Covered Charges for a Covered Person's care in these facilities are limited to the following Services or Supplies:

(1) Maximum day limit as shown in the “Schedule of Benefits”;

(2) Room and Board charges, including general nursing care. Private room charges are limited to the Average Semi-Private Room Rates. You will be responsible for the payment of charges over the facility’s Average Semi-Private Room Rate unless the private room is ordered by the attending Physician and found Medically Necessary.

(3) Rehabilitative physical, occupational, speech or respiratory/inhalation therapies;

(4) Medical social Services; and

(5) Ancillary or miscellaneous Services or Supplies, appliances, or equipment that are ordinarily provided and billed by the facility and given by employees of the facility.

Outpatient SNF Services

(1) **Rehabilitative Therapy**. Benefits are available for Outpatient physical therapy, cardiac rehabilitation, occupational, speech therapy and inhalation/respiration therapy rendered to improve function lost due to an Illness or Injury. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the “Schedule of Benefits” for benefit limits.

(2) **Other Outpatient Services and Supplies.** Benefits are available for other Outpatient facility Services or Supplies when found Medically Necessary according to Plan provisions. Coverage includes all necessary Supplies used during the Covered treatment.

HOME HEALTH CARE

Charges for and Approved Plan of Care for Home Health Care Services and Supplies are Covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility Confinement as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. §1395 et seq, would otherwise be required. The diagnosis, care and treatment must be certified in writing by the attending Physician and be contained in a Home Health Care Plan. These benefits stop when Home Health Care is no longer needed instead of Inpatient Care.

Benefit payment for nursing, Home Health Aide and therapy Services is subject to the Home Health Care limits shown in the "Schedule of Benefits".

To be Covered, Home Health Care must be ordered and given under the supervision of the attending Physician, Services and Supplies must be included in the approved Home Health Care Plan, and furnished by and coordinated by the Home Health Care Agency. Coverage is limited to Allowed Charges for one or more of the following Services or Supplies billed by the Home Health Care Agency:

(1) Part-time or intermittent home nursing care by, or under the supervision of, a registered professional nurse (RN). Full-time care is not Covered;

(2) Part-time or intermittent Home Health Aide Services which consist primarily of caring for the patient. Full-time care is not Covered;

(3) Physical, occupational or speech therapy if provided by the Home Health care Agency;

(4) Medical Supplies, drugs and medicines prescribed by a Physician, and that would be allowed had the patient been confined in a Hospital or Skilled Nursing Facility as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. §1395 et seq;

(5) Laboratory services by or on behalf of a Home Health Care Agency that would have been Covered had the patient been confined in a Hospital or Skilled Nursing Facility as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. §1395 et seq;

(6) Medical social Services; or

(7) Nutritional Services provided by a licensed dietitian.

A Home Health Care visit will be considered a periodic visit by a Covered member of the Home Health Care team, or up to four hours of Home Health Aide Services. Benefits for visits during an Approved Plan of Care are limited to a Calendar Year maximum. Once this visit maximum has been paid, these benefits stop for the remainder of that Calendar Year.

The following expenses are not Covered:

(1) Services or Supplies that are not included in the approved Home Health Care Plan.

(2) Services that are given by Immediate Relatives.

(3) Services given to persons living in the household, other than the patient for whom the Home Health Care was approved.

(4) Services or Supplies given while the patient was not under the care and supervision of a Physician.

(5) Services or Supplies that are not given by, or coordinated by, and billed through an approved Home Health Care Agency.

HOSPICE CARE

Charges for Hospice Care Services and Supplies are Covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

The Hospice care program must be established by, and reviewed regularly by, the attending Physician and the appropriate personnel of the Hospice Care Agency. The Hospice care must be intended to provide palliative and supportive care to the terminally ill patient and supportive care to their families. A written evaluation must be prepared by the Hospice coordinator showing the patient's medical and social needs with a plan of care and Services needed to meet those needs.

Covered Charges for Hospice Care Services and Supplies are payable as described in the "Schedule of Benefits". Covered Hospice expenses include the following Hospice Services or Supplies when part of an Approved Plan of Care:

(1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed;

(2) Day care service provided by the Hospice Agency;

(3) Home care and Outpatient Services provided by the Hospice including intermittent nursing (up to eight hours a day) by a registered nurse or licensed practical nurse, or Home Health Aide;

(4) Physical, occupational, speech, and respiratory therapy;

(5) Psychological counseling, medical social Services and nutritional Services;

(6) Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;

(7) Medical Supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature. **Exception:** As required by applicable New York State Law, if a drug has been approved by the FDA for the treatment of certain types of cancer, this Plan is required to cover these drugs if prescribed for the treatment of certain types of cancer. This Plan is required to cover those drugs if prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. However, Coverage is not required for any Experimental or Investigational drug, or any drugs which the FDA has determined to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed. Benefits will be provided for Experimental drugs and medicines if required pursuant to an external appeal;

(8) Medical care, consultations, or case management Services provided by the Hospice Physician or other Physician designated by the Hospice Care Agency to render Hospice Services;

(9) Intermittent respite care (care furnished during a period when the person's family or usual caretaker cannot, or will not, attend to the person's need); and

(10) Bereavement counseling for the Covered Person's family up to a maximum of five visits any time during the Hospice acceptance or up to 12 months following the Covered Person's death.

During this period of acceptance, all the patient's medical Services must be provided by or obtained through the Hospice Agency. All Services must be billed by the Hospice Agency.

If the patient or his or her family chooses to stop Hospice care or if Services are not obtained through the Hospice care Agency, then benefits will be provided for medical Services or Supplies that are otherwise Covered according to Plan provisions. This applies whether or not related to the terminal Illness.

URGENT CARE FACILITY, as defined, for urgent care Services and Supplies.

MEDICAL/SURGICAL SERVICES AND SUPPLIES

SURGICAL CHARGE BENEFITS

This benefit applies when a surgical charge is Incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is Covered for this benefit.

It may be the fee of the surgeon, the assistant surgeon or the anesthesiologist.

Care and treatment for voluntary surgical sterilizations are Covered for you and your Covered Spouse. Dependent children Coverage and sterilization reversal procedures are excluded.

Traditional Option only. Surgical, assistant surgical and anesthesia benefits are paid based on the Scheduled Surgical Allowance up to the maximum shown in the "Schedule of Benefits". The balance of Allowed Charges are payable at 80% after Deductible. Percentage Coinsurance Out-of-Pocket limit applies. **Exception:** Ambulatory Surgery benefit as shown below.

Ambulatory Surgery Benefit- Traditional Option only. The following specified surgical procedures are Covered at 100% of Allowed Charges for Services rendered by a surgeon, assistant surgeon or anesthesiologist in an Outpatient Hospital, Ambulatory Surgical Facility, Urgent Care Center, clinic or Provider's office. However, if the listed procedures are rendered during an Inpatient Hospital/facility stay, then the Services will be Covered at 80% of Allowed Charges after Deductible. Percentage Coinsurance Out-of-Pocket limit applies. This benefit applies only to the following listed surgical procedures that are not considered integral to or part of another Surgery.

Adenoidectomy
Breast biopsy
Cervical biopsy
Cryosurgery
Deviated septum
Dilatation and curettage (non-obstetrical)
Laparoscopic sterilization (tubal ligation)
Laparoscopy
Sigmoidoscopy
Tonsillectomy, with or without adenoids
Tubal ligation
Varicose veins
Vasectomy

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(1) If r multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowed Charge for the primary procedure; and 50% of the Allowed Charge for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowed Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowed Charge for that procedure.

Traditional Option only. The multiple Surgery 50% allowance for additional procedures, will be based on Allowed Charges at 50% of the Scheduled Surgical Allowance, up to the maximum shown in the "Schedule of Benefits". The balance of Allowed Charges (if any) are payable at 80% after Deductible. Percentage Coinsurance Out-of-Pocket limit applies.

Assistant Surgeon

Charges for assistant surgeon Services are Covered when found Medically Necessary for performance of the Covered procedure. Inpatient surgical procedures must be done in a Hospital or other Covered facility where there is no qualified staff available to assist the surgeon. A Hospital or other facility regulation, in itself, does not establish Medical Necessity. A licensed Professional Healthcare Provider qualified to render the surgical assistance must give and bill for the assistance. The maximum Allowed Charge for the surgical assistant will be based on 20% of the corresponding primary Surgery value.

> **Traditional Option only.** The maximum Allowed Charge 20% allowance for assistant Surgery procedures, will be based on Allowed Charges at 20% of the Scheduled Surgical Allowance, up to the maximum shown in the "Schedule of Benefits". The balance of Allowed Charges (if any) are payable at 80% after Deductible. Percentage Coinsurance Out-of-Pocket limit applies.

Anesthesia

Benefits are available for administration of General Anesthesia found Medically Necessary for Covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee other than an Advanced Physician Care Extender. **Exception:** Administration of anesthesia by a dentist who performed the Surgery is Covered when the anesthesia is rendered during a Covered oral surgical procedure. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after Surgery. Anesthesia administration expenses are not Covered if the Surgery is not Covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: Covered electroshock therapy.

> **Traditional Option only.** Anesthesia benefits are paid based on the Scheduled Surgical Allowance for the corresponding surgical procedure, up to the maximum shown in the "Schedule of Benefits". The balance of Allowed Charges (if any) are payable at 80% after Deductible. Percentage Coinsurance Out-of-Pocket limit applies. **Exceptions:** For those listed Outpatient ambulatory surgical procedures listed above, the corresponding anesthesia benefits are Covered at 100% of Allowed Charges. Anesthesia for Covered non-surgical administration and anesthesia for those listed ambulatory surgical procedures performed in an Inpatient setting are payable at 80% of Allowed Charges after Deductible. Percentage Coinsurance Out-of-Pocket limit applies.

Maternity

The Allowed Charges for the care and treatment of Pregnancy are Covered the same as any other Sickness.

> Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for Services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care (including miscarriage and spontaneous abortion) rendered for you and your Covered Dependents. Coverage is not provided for expenses connected with elective abortion unless documented evidence shows Medical Necessity for the termination of the Pregnancy. The Plan excludes Service or Supplies related to surrogate maternity care. The payment for childbirth, cesarean section or other termination of a Pregnancy will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care). However, Plan benefits may be divided to up to two payments for Services rendered during prenatal care and one payment for delivery and postnatal care.

Reconstructive Surgery

The Plan Covers care required to significantly restore tissue damaged by an Illness or Injury 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.

Reconstructive mammoplasties will also be considered Covered Charges. The federally and state mandated mammoplasty Coverage will include reimbursement for:

(1) reconstruction of the breast on which a mastectomy has been performed,

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(3) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

TRANSPLANTS - Organ/Autologous Bone Marrow/Stem Cell

Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included for Medicare Coverage by the Centers for Medicare & Medicaid Services (CMS). Transplants must meet the Medicare criteria for Coverage to be considered for Coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for Coverage. Plan Coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts Coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital. **Exception:** The Plan will provide Coverage for expenses related to an Experimental transplant if required pursuant to external appeal.

Benefits will be available for the following in connection with a Covered transplant.

(1) Recipient Expenses. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to Covered organ transplants (examples- pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant Surgery and recovery; and post discharge care).

(2) Donor Expenses

(a) If the donor is eligible and enrolled in this Plan and the recipient is not Covered under the same family Coverage, Coverage will be provided the same as an Illness for expenses Incurred while the donor is Covered under the Plan. Benefits will be payable under the donor's Coverage.

(b) If the donor is not a Covered Person under this Plan, Coverage will be provided under the recipient's Coverage and limited to expenses not payable by the donor's Plan. Such Coverage will be provided the same as an Illness for expenses Incurred while the recipient is eligible and enrolled as a Covered Person under the Plan. Benefits will be payable under the recipient's Coverage. The donor's expenses will count toward the recipient's Plan benefit maximums.

(c) If both the donor and recipient are eligible and enrolled in the Plan, expenses will be treated separately for each Covered Person. The donor's expenses will be paid under the donor's own Plan Coverage and the recipient's expenses will be paid under his or her own Plan Coverage.

(d) The Usual, Reasonable, and Customary Charges for securing an organ from a cadaver or tissue bank will be considered Covered expenses for non-Experimental transplants Incurred by the recipient while eligible and enrolled in the Plan. This Coverage includes expenses for the surgeon's removal of the organ from the cadaver, and the Hospital's storage or transportation of the organ. Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the Services were rendered before such date. No benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member.

(3) Autologous Bone Marrow/Stem Cell. Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not Covered as organ and tissue transplants, except for the following (and only then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting Coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for Covered procedures will be considered on the same basis as organ transplants shown above.

IN-HOSPITAL/FACILITY PHYSICIAN'S CARE BENEFITS

This benefit applies when a medical charge is Incurred for the care of a Covered Person's Injury or Sickness during a Covered Hospital/Facility Confinement.

However, a medical charge will not include:

(1) A charge for care not rendered in the presence of a Physician; or

(2) A charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required Surgery.

(3) Inpatient Substance Use Disorder (rehabilitation) visits are not Covered under this benefit; refer to subsection "Inpatient Substance Use Disorder" shown previously in this document under the section entitled "Hospital and Other Facility".

SPECIALIST CONSULTATIONS

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations. When the attending Physician refers a patient to a specialist or other Physician for the management (treatment) of an Illness or Injury, the visits are not considered consultations.

(1) Inpatient Consultations. Coverage for Inpatient consultations is provided for as many opinion consultations as Medically Necessary.

(2) Outpatient/Office Consultations. Coverage for Outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.

(3) Second Opinion Consultation. Benefits are available for patient-requested second opinion consultations before proceeding with a Covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the consulting specialist renders the procedure, consultation benefits are not payable. Whether or not the second opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

(4) Second Opinion Consultation for Cancer Diagnosis. Benefits are also available for a second medical opinion from a board certified specialist whose specialty is appropriate to give such opinions (examples- a specialist affiliated with a specialty care center for the treatment of cancer), in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

OUTPATIENT PHYSICIAN CARE

The professional Services of a Physician for evaluation and management or therapeutic medical visits in an office, Outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by Covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, allergy care, Mental Disorder care, and Substance Use Disorder care are Covered separately. Physician's charges for emergency room visits are Covered as shown in the "Schedule of Benefits".

FOOT CARE AND PODIATRY SERVICES

Benefits are available for treatment related to care of the feet. Coverage includes Services or Supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Coverage for foot care is provided on the same basis as care for other Illness or Injuries. However, charges for routine foot care is not Covered. **Exception:** Charges for routine foot care are Covered for patients with severe systemic disorders, such as diabetes.

DIAGNOSTIC TESTING, X-RAY AND LAB CHARGE BENEFITS

Diagnostic Testing, X-ray and Laboratory charges are the Allowed Charges for X-rays and laboratory tests. Benefits are provided for diagnostic Services required in the diagnosis of a condition due to Injury or Sickness consisting of:

(1) Diagnostic radiology, ultrasound, nuclear medicine, and necessary Supplies.

(2) Diagnostic medical Services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician.

(3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician.

(4) Allergy testing when performed and billed for by a Physician.

Coverage includes separate Physician's charges for interpretations of Covered diagnostic Services given by a Hospital, Skilled Nursing Facility or other Covered facility.

Traditional Option only. Laboratory professional interpretation charges have a separate Illness or Injury limit. Also, benefits for allergy care count toward a separate benefit limit for allergy care. Refer to "Allergy Care" Traditional Option only below and the section entitled "Schedule of Benefits", subsection "Medical/Surgical Services and Supplies" shown previously in this document for details.

Charges for the following will not be included in this section:

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

(4) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

ALLERGY CARE

Benefits are available for Covered expenses related to the diagnosis and treatment of a allergies given and billed by Covered Professional Healthcare Providers. Covered expenses under this benefit include the initial examination, diagnostic tests and resulting therapies. Refer to the section entitled “Schedule of Benefits”, subsection “Medical/Surgical Services and Supplies” shown previously in this document for details.

KIDNEY DIALYSIS

Benefits are available for Service or Supplies related to Outpatient kidney dialysis procedures given and billed by Physicians, Hospitals or Medicare-certified dialysis centers. Home self-dialysis is also Covered when ordered by the attending Physician and home setting is found medically appropriate according to Plan provisions. If you are on home dialysis, Coverage includes related laboratory tests and consumable or disposable Supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be Covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

RADIATION/CHEMOTHERAPY BENEFITS

This benefit applies when a radiation or chemotherapy charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is Covered for this benefit.

Radiation Charge and Limits

A radiation charge is the Allowed Charge of a Physician for X-ray, radium or radiotherapy treatment.

Radiation charges will not include charges for diagnostic or Cosmetic Procedures. Charges for office visits or consultations are Covered separately.

Chemotherapy Charge and Limits

A chemotherapy charge is the Allowed Charge of a Physician for chemotherapy.

The type of drug for which benefits are provided is limited to drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs).

Coverage includes professional chemotherapy Services and related Supplies. Home chemotherapy includes chemotherapy Supplies, non-Experimental drugs and equipment used in the home when the home setting is found medically appropriate according to Plan provisions. Chemotherapy drugs purchased from a Pharmacy and are not Investigational will be considered under the “Prescription Drug Benefit” shown later in this document.

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not Covered under this chemotherapy benefit. Charges for office visits or consultations are Covered separately. Experimental drugs and related care are not Covered. **Exception:** For cancer drugs only, by New York State Law, if a drug has been approved by the FDA for the treatment of certain types of cancer, this Plan is required to cover those drugs if prescribed for treatment of a type of cancer for which the drug has not been approved by the FDA. However, Coverage is not required for an Experimental or Investigational drug, or any drugs which the FDA has determined to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed.

OUTPATIENT TREATMENT FOR MENTAL DISORDERS

Covered Charges for care, Supplies and treatment of Mental Disorders will be covered as shown in the "Schedule of Benefits". Care and treatment must be directed at a diagnosed Mental Disorder. Benefits are not payable for care 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.

Coverage for Outpatient Mental Disorder care also includes the following treatment.

(1) Treatment of biologically-based mental Illness for adults and children is Covered. "Biologically-based mental Illness" is defined as a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Illness (such as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia).

(2) Treatment of serious emotional disturbances in children under age 18 years is Covered, when related to attention deficit disorder, disruptive behavior disorders or pervasive development disorders and where there are one or more of the following:

- **(a)** serious suicidal symptoms or other life-threatening self-destructive behavior;
- **(b)** significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- **(c)** behavior caused by emotional disturbances that placed the child at risk of causing personal Injury or significant property damage; or
- **(d)** behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

OUTPATIENT TREATMENT FOR SUBSTANCE USE DISORDER

Covered Charges for care, Supplies and treatment of Outpatient Substance Use Disorder will be covered as shown in the Schedule of Benefits for Services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an Approved Plan of Outpatient Care. You should obtain pre-approval from the Claims Administrator before treatment begins to be sure that the facility or agency meets Plan requirements. (Pre-approval does not guarantee benefits. Determination of Plan benefits will be based on Plan limitations and exclusions in effect at the time Services are Incurred.)

Benefits are not payable for Services that consist primarily of participation in programs of a social, recreational, or companionship nature.

REHABILITATION THERAPY

Benefits are available for Outpatient acute care rehabilitative therapy to restore function lost due to Illness or Injury. Therapy that is part of an Approved Plan of Care for Home Health care or Hospice benefits are Covered separately. Benefit limits are described in the Schedule of Benefits for:

(1) Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.

(2) Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

(3) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, Maintenance Care (therapy), or Supplies used in occupational therapy. Coverage does not include care directed at employment or educational deficits.

(4) Cardiac rehabilitation for Outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending Physician and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart Surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass Surgery or angioplasty; or stable angina. The Plan of Care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan Coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are Covered. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not Covered.

(5) Inhalation/Respiratory therapy for short-term Outpatient inhalation therapy when ordered by the attending Physician for therapy Services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not Covered.

DURABLE MEDICAL EQUIPMENT (DME)

Rental of Durable Medical Equipment when ordered by a qualified Professional Healthcare Provider and found Medically Necessary according to Plan provisions is Covered. The equipment must customarily be used for therapy and suitable for home use. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase only when it cannot be rented, or when the duration of the DME is needed makes the purchase less expensive than rental. The purchase of DME requires advance written approval from the Claims Administrator. Such approval is not a guarantee of benefits. Coverage will be provided based on medical documentation and Plan limitations in effect at the time the DME is purchased.

The necessary repairs and maintenance of purchased equipment may be allowed, unless Covered by a warranty or purchase agreement. Coverage includes the necessary Supplies to operate the DME. Charges for delivery and service are not Covered. Duplicate equipment is not Covered, whatever the reason.

PROSTHETICS

The initial purchase, fitting and repair of fitted Prosthetic devices which replace body parts when ordered by a qualified Professional Healthcare Provider is Covered. Replacement may be Covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. Otherwise the replacement or repair of Prosthetics is not Covered. This Plan specifically excludes wigs, hairpieces, and Biomechanical Prosthetics (microchip). Specialized Prosthetics are excluded when standard Prosthetics are adequate for the patient's condition. Duplicate Prosthetics are not Covered for any reason.

ORTHOTICS

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an Injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness when ordered by a qualified Professional Healthcare Provider. Replacement may be Covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. This Plan specifically excludes foot Orthotics and other foot devices used for routine foot care or misalignment of the feet, or devices for athletic use. Specialized Orthotics are excluded when standard Orthotics are adequate for the patient's condition. Duplicate Orthotics are not Covered for any reason.

OXYGEN

Oxygen and Supplies for its administration when found Medically Necessary and appropriate for self-care home use when ordered by the attending Physician.

MEDICAL SUPPLIES (Home Use)

Benefits are available for certain medical and surgical Supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not Covered. Coverage is limited to the following items:

(1) Ostomy bags and Supplies required for their use.

(2) Catheters and Supplies required for their use.

(3) Syringes and needles necessary for conditions such as diabetes.

(4) Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

BLOOD SERVICES

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included.

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. Benefits are not available for separate charges billed for autologous or directed blood, or blood products, or for storage of autologous or directed blood.

CONTACT LENSES/EYEGLASSES FOLLOWING INTRAOCULAR OR CATERACT SURGERY

Initial contact lenses or glasses and exam required following intraocular Surgery or cataract Surgery. No other eyeglasses, contact lens or visual aids, or related exams are Covered under this benefit.

LIMITED DENTAL CARE

Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(1) The diagnosis and treatment of oral tumors and cysts.

(2) Treatment of Injury to Sound Natural Teeth or jaw that is rendered within 12 months of the Injury, including all related care, Supplies and Prosthetics.

(3) Services or Supplies connected with treatment due to congenital disease or anomaly.

(4) Medically Necessary Services for care and treatment of Temporomandibular Joint syndrome.

In no event will the Plan cover the costs for repair or replacement of damaged crowns, false teeth, orthodontic braces or any other dental devices. Plan benefits are available in the same manner as medical expenses based on the Plan Option selected.

HEARING AID(S)

(1) **Resulting from Surgery.** Benefits are available for the initial hearing aid(s) that are required due to hearing loss resulting from a surgical procedure given while the Covered Person was eligible and enrolled in the Plan. Coverage includes the initial hearing aid and the related exam for fitting the aid. No other hearing aids or related exams are Covered under this benefit.

(2) **Medically Necessary Hearing Aids (Provider Choice Option only).** Coverage is available up to the benefit limits described in the "Schedule of Benefits" for Medically Necessary hearing aids and the related exam and fitting.

DIABETIC SUPPLIES, EQUIPMENT, AND EDUCATION

(1) The following Supplies and equipment are Covered for the treatment of a diabetic condition when such Supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

  (a) Blood glucose monitors (standard) and blood glucose monitors for the visually impaired;

  (b) Test strips for glucose monitors, visual reading and urine testing;

  (c) Injection aids;

  (d) Cartridges for the visually impaired;

  (e) Syringes;

  (f) Data management systems;

  (g) Insulin pumps or insulin infusion pumps and related supplies;

  (h) Insulin and Oral Agents to control blood sugar.

Coverage will be provided for additional diabetes equipment and Supplies as required under the regulations of the New York State Commissioner of Health.

Insulin and oral agents to control blood sugar is Covered under this provision or under "Prescription Drug Benefits" shown later in this document. Benefits are available under whichever Coverage is more

advantageous to you or your Dependent.

(2) Diabetic self-management education and education relating to diet may be Covered for a Covered Person with a diabetic condition. Self-management education or diet instruction will only be Covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational Services will be Covered when provided by:

(a) A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;

(b) A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient's area, the Plan will cover individual education;

(c) A professional Provider as described above will be Covered for Services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive Services at home.

CHIROPRACTIC CARE

Spinal Manipulation/Chiropractic Services by a licensed doctor of chiropractic (D.C.) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening.

INFERTILITY

Benefits are available for Services or Supplies related to treatment or Infertility for Covered Persons age 21-44 years old (or any age for treatment of a correctable medical condition otherwise Covered by the Plan that results in Infertility). The diagnosis and treatment of Infertility must be prescribed by a Physician in a plan of care. Services must be rendered by qualified healthcare Providers, and be consistent with the guidelines established and adopted by the New York State Insurance Department by regulation. New York State Insurance regulations are those standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists (ACOG) and the American Society for Reproductive Medicine (ASRM). Covered Services include:

(1) Inpatient or Outpatient surgical or medical procedures that would correct malformation, disease or dysfunction resulting in Infertility (examples- artificial insemination, dilatation and curettage (D & C), and other Medically Necessary surgical or medical procedures unless excluded by law); and

(2) Diagnostic tests and procedures provided to determine Infertility or that are necessary in connection with any surgical or medical Infertility treatments (examples- hysterosalpingogram, hysteroscopy, endometrial biopsy, laparascopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound, and other Medically Necessary diagnostic test and procedures unless excluded by law); and

(3) Prescription Drugs approved by the Federal Food and Drug Administration for use in the diagnosis and treatment of Infertility, including induction of Pregnancy, and which are not related to excluded services. Refer to the section entitled "Prescription Drug Benefits" shown later in this document for additional details.

Specifically excluded from coverage for the diagnosis and treatment of Infertility are the following Services and

procedures: in-vitro fertilization; gamma intrafallopian tube transfers (GIFT); zygote intrafallopian tube transfers (ZIFT); reversal of elective sterilizations; sex change procedures; cloning; sperm banking and donor fees associated with artificial insemination or other procedures.

Coverage for Infertility will be provided in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

PHARMACY PRESCRIPTION DRUG BENEFITS

(1) When this Plan is primary, Prescription Drug benefits are only available through CVS/Caremark your Prescription Drug Benefits Claims Administrator. Benefits are not available under the medical benefits. Please refer to the section entitled "Prescription Drug Benefits" shown later in this document for details.

(2) When another plan is considered primary, Coverage according to the COB order of benefit determination, you must obtain prescription benefits through the primary plan first, then file a claim with POMCO. Prescription Drug Benefits through CVS/Caremark are not available. All benefit drug limitations and exclusions apply as noted in the section entitled "Prescription Drug Benefits" shown later in this document.

If this Plan is secondary do not show your Jefferson Lewis et. al. Schools Employee Healthcare Plan identification card at the time of purchase. Claims should first be submitted to the primary plan and then you may obtain a POMCO claim form from your Participating School healthcare clerk or from POMCO. Complete the claim form and attach your original Prescription Drug receipt (receipt should include dates of purchase, name of drug, dose and RX#) and a copy of the primary plan's explanation of benefits and mail to POMCO. All benefit limitations and exclusions apply as noted in the "Prescription Drug Benefits" shown later in this document.

CARE TEAM CONNECT™FOR HEALTH

If you have a health question or issue, Jefferson–Lewis et. al. Employees' Healthcare Plan has allied with a Nurse Help Line to provide you with *fast, free, and private* assistance from trained registered nurses or health care counselors 24 hours a day, seven days a week, 365 days a year, including holidays and weekends.

Registered nurses are available to answer questions if you:

- Need help to decide if you need to go to the emergency room or to your doctor's office;
- Need information concerning a medical test;
- Have a question about a health condition that you have;
- Have concerns that you do not wish to discuss with your doctor.

If you are diagnosed with asthma, diabetes, or heart failure or other long-term condition, a Care Team Connect™ health care counselor will:

- Provide you with more information about this program;
- Provide your Physician with periodic updates;
- Answer all your questions, discuss your doctor's treatment plan, and provide you with the latest information about your condition;
- Help you take charge of your chronic medical condition.

This confidential added service is available by phone only. Call the Care Team Connect™ Health Nurse Help Line at:

1-888-967-8839 for 24/7 Nurse Help Line

1-800-694-7828 for Disease Management

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accidental Injury is a bodily Injury caused by an event. The breakdown or fracture of natural teeth or other dental condition caused by chewing will not be considered an Accidental Injury.

Accredited Secondary School is a college or university or other institution accredited in the current American Council on Education publication of Accredited Institutions of Post-Secondary Education.

Acute Care General Hospital or Hospital is an institution which is primarily engaged in providing, by or under the continuous supervision of a Physician, to Inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of Injured or sick persons at the patient's expense and which fully meets these tests: has organized departments of medicine and major surgery; has a requirement that every patient must be under the care of a Physician or dentist; provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); if in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of United States Public Law 89-87 (42 U.S.C.A. 1395x (k); if not in New York State it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association Healthcare Facilities Accreditation Program, or a national accreditation organization recognized by the Claims Administrator; it is approved by Medicare as a Hospital; is duly licensed by the agency responsible for licensing such hospitals; and is not a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, Custodial, education or rehabilitory care.

Advanced Physician Care Extender or Physician Extender includes physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Allowed Charge(s)

(1) Medical Benefits are the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered medical Services rendered and billed by a Covered Out-of-Network Provider. For Traditional Option, Allowed Charges are based on the 50th percentile of current fee data profiles. For the Provider Choice Option, Allowed Charges are based on the 85th percentile of current fee data profiles. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan and or any applicable Copayments, Deductibles or Out-of-Pocket limit amounts.

(2) Prescription Drug Benefits is the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered Pharmacy Services rendered and billed by a Covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network negotiated rates. The Enrollee is responsible for payment of any charges that are not allowed under the Plan and or any applicable Copayments, and if an Out-of-Network Pharmacy is used, the Covered Person is responsible for the payment of charges more than the Usual, Reasonable, and Customary Allowed Charges.

(3) Vision Care Benefits (Provider Choice Option only) is the set fee schedule as shown in the "Schedule of Benefits" for Covered Vision Care Services rendered and billed by a Covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network Negotiated rates. The Enrollee is responsible for payment of any charges that are not allowed under the Plan, and if an Out-of-Network Vision Care Provider is used, the Covered Person is responsible for the payment of charges more than the set fee schedule shown in the "Schedule of Benefits".

Ambulatory Surgical Center is a licensed facility that is used mainly for performing Outpatient Surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Care, a national accreditation organization recognized by the Claims Administrator, or approved by Medicare to render Outpatient Surgery Services.
If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Facility.

Ambulatory Surgery means Surgery given on other than an Inpatient basis. For example, in a Physician's office, clinic, Outpatient department of a Hospital, Ambulatory Surgical Center or other Outpatient location.

Amend/Amendment is a change, revision, deletion, or addition to the Plan Document and/or Summary Plan Description duly made, and signed by an authorized representative of the Plan Administrator and approved by the Superintendent of the New York State Insurance Department, if required under the applicable articles of the New York Insurance Law.

Approved Plan of Care means any service or course of treatment approved for benefits under the terms and limitations of the Plan.

Average Semi-Private Room Rate is the standard semi-private rate for Room and Board charges by a Hospital or other Covered Inpatient health facility. If the Inpatient facility does not have a semi-private rate, the rate will be deemed to be 90% of the Room and Board charges made by the Facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the facility's most common rate will be used. Semi-private accommodations are generally rooms with two or more beds.

Biomechanical Prosthetic Device is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician or a nurse-midwife licensed pursuant to Article 140 of the NYS Education Law, practicing consistent with a collaborative relationship with a Physician; and a registered nurse (R.N.); and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre-or post-delivery Confinement.

Brand Name Drug means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Calendar Year Deductible is the amount of Allowed Charges that must be paid by the Enrollee each Calendar Year before certain benefits can be determined under Plan provisions. See also Deductible.

Claims Administrator is the person or organization under contract with the Plan for the processing and determination of benefits under the Plan.

COBRA means the continuation of Plan Coverage according to Federal regulations under the Consolidated Omnibus Budget Reconciliation Act of 1986 and subsequent Federal and New York State COBRA regulations affecting this type of Plan.

Confinement is the period starting with the date of the patient's admission to an Inpatient facility that provides Hospital or nursing care and ending with the date the patient is discharged.

Continuous Confinement means consecutive days in of In-Hospital, Psychiatric Facility, Substance Use Disorder Facility, Skilled Nursing Facility, Birthing Center or for Home Health Care Agency services in lieu of Hospitalization when discharge from, and readmission occurs, within a period of 90 days due to the same or related causes.

Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some Services and other Services will not have any Copayments. Copayments do not accrue toward the 100% maximum Out-of-Pocket limit. The Covered Person is responsible for payment of the Copayment amounts.

Cosmetic Procedure is a procedure performed solely for the improvement for a Covered Person's appearance, rather than for the improvement or restoration of bodily functions.

Covered Charge(s), Coverage or Covered means those Medically Necessary Services or Supplies that are Covered under this Plan.

Covered Person is any person eligible and enrolled for benefits or Coverage under this Plan.

Covered Services and Supplies are Medically Necessary Services and/or Supplies, or other care, specifically shown as Covered Charges according to Plan provisions and not otherwise specifically excluded under the Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered..

Deductible is the amount of Allowed Charges that must be paid by the Enrollee before certain benefits can be determined under Plan provisions. See also Calendar Year Deductible.

Dependent is an Enrollee's legal Spouse or child who meets the eligibility and enrollment conditions as shown in this Plan.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable Supplies may be allowed if required to operate the medical equipment.

Effective Date is the date Coverage is effective with respect to an eligible and enrolled Employee or Dependent, after designated Waiting Periods. See Waiting Period.

Employee means any person who is considered an eligible Employee or Retiree according to criteria established by the Plan as set forth in the section entitled "Eligibility, Funding, Enrollment, Effective Date and Termination" shown previously in this document. It does not mean persons without employment or Retiree status such as former Employees that have been terminated or laid off unless continuing Coverage during an authorized Leave of Absence or during a COBRA or active military reservist period (USERRA).

Employer see Participating School.

Employment Status. An Employee is considered in active employment when he or she is on the regular payroll of the Participating School and does, for the Employer, all the substantial and material duties of the job and regularly works the minimum hours per day or week established by the Employer for full-time employment or a full-time Employee who is on an approved paid absence or unpaid FMLA.

Enrollee is an eligible Employee, Retiree, survivor Spouse, or COBRA participant under whose Member ID number enrollment is made.

Enrollment Date is the first day of Coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means Services, Supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time Services were rendered.

The Claims Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Claims Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Claims Administrator will be guided by the following principles:

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

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

If any of the entities used to determine the Investigational status of a drug, 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 related 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.

Exception: For cancer drugs only, by New York State Law, if a drug has been approved by the FDA for the treatment of certain types of cancer, this Plan is required to cover those drugs if prescribed for treatment of a type of cancer for which the drug has not been approved by the FDA. However, Coverage is not required for an Experimental or Investigational drug, or any drugs which the FDA has determined to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed. Benefits will also be provided for Experimental drugs and medicines if required pursuant to an external appeal.

Family Members are the Enrollee and his or her eligible Dependents enrolled in the Enrollee's family Coverage.

Family Unit is the Enrollee and the Family Members who are Covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically Covered by this Plan.

Foster Child means a child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a Covered Employee or Retiree has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the Covered Employee's or Retiree's; and the child meets the definition of "foster child" under Internal revenue Code 152 (f) (1).

A Covered Foster Child is not a child temporarily living in the Covered Employee's or Retiree's home; one placed in the Covered Employee's or Retiree's home by a social service agency which retains control of the child; or whose biological parent(s) may exercise or share parental responsibility and control.

General Anesthesia means 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.

Generic Drug means a Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Aide is a person other than a Physician or a nurse, who provides care that is primarily to aid a homebound patient in performing daily activities as part of an Approved Plan of Home Health Care. The aide must report to, and be under the direct supervision of, a Home Health Care Agency that bills for the aides' Services.

Home Health Care Agency is a licensed agency or Hospital that has been issued a current valid certificate of approval or license as a certified home health agency under Article 36 of the Public Health Law by the New York State Department of Health. Outside New York State, the agency must have a similar operating certificate issued by the state of jurisdiction; or be certified by Medicare as a participating Home Health Care Agency.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital Confinement (or convalescent nursing home/extended care facility/Skilled Nursing Facility); and it must specify the type and extent of Home Health Care required for the treatment of the patient. The patient must remain under the supervision and care of the attending Physician during the period Home Health Care is provided.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent Home Health Aide Services provided through a Home Health Care Agency (this does not include general housekeeping Services); physical, occupational and speech therapy; medical social Services; medical Supplies; and laboratory Services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and has been certified to provide these services pursuant to Article 40 of the NYS Public Health Law, with the appropriate operating certificate issued by New York State Department of Health to provide Hospice Care and meets the standards of the National Hospice Organization. Outside of New York State, the Hospice organization must be duly licensed and certified under a similar certification process required by the state in which the Hospice is located; or it must be approved by Medicare; and it must meet the standards of the National Hospice Organization.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

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

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are not expected to live more than six months due to terminal Illness.

Hospital - See Acute Care General Hospital.

Hospitalist is a Physician that assumes the care of hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Immediate Relative of patient or Enrollee - 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.

In-Network Provider is 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 Plan to bill negotiated charges or allowances for Covered Services or Supplies when Incurred by Covered Persons.

Incurred means 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.

Infertility means the inability to achieve a Pregnancy after 12 months of regular unprotected intercourse. Earlier evaluation may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient or Inpatient Care is the period during which a Covered Person was treated in a Hospital, Skilled Nursing Facility or other Covered Inpatient facility as a registered bed patient for whom Room and Board charges are made.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Investigational - See Experimental.

Late Entrant is an eligible Employee or Dependent who is enrolled for Plan Coverage after his or her initial enrollment eligibility period, usually more than 30 days after an initial eligibility.

Leave of Absence is an Employee who does not meet the actively- at-work requirement, whether or not receiving wages or remuneration, is eligible to continue under the Plan with specific advance written approval of the Participating School.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while Covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maintenance Care is care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected, and/or 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 Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency is a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy (or others, if severe behavioral condition), impairment to bodily function, dysfunction of any organ, or serious disfigurement.

Medically Necessary are professional medical Services, drugs, Supplies, devices, equipment or items provided to a Covered Person for the treatment of an Illness or Injury when it meets the following conditions:

(1) It is consistent with the symptom or diagnosis and treatment of the Illness, Sickness, disease, ailment or Injury;

(2) It is according to generally accepted standards of good medical practice in the USA at the time expenses Incurred;

(3) It is not solely for the convenience or personal comfort of the Covered Person, Physician, other caregiver or member of the family;

(4) It is the most appropriate level of service, drugs, Supplies or equipment that can be safely provided to the Covered Person. With respect to Inpatient Care, appropriate level of service means that the medical condition requires Inpatient Care and that safe and effective treatment cannot be given as an Outpatient.

(5) It is not of an educational nature or not provided primarily for medical or other research;

(6) It is not considered Maintenance or Custodial Care; and

(7) It is care requiring the credentials and technical skills of the Provider of service.

The fact that a Physician or other health care professional may prescribe, recommend, order or approve a Service or Supply does not, by itself, determine Medical Necessity or make such service or supply eligible for benefits, even if not expressly excluded under the Plan. The Claim Administrator reserves the right to decide 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 Centers for Medicare and Medicaid Services (CMS), or any similar entities;

(2) The National Medical Associations, Societies and Organizations;

(3) The FDA; or

(4) The Claim Administrator's or Plan Administrator's own medical and legal consultants and advisors.

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 for such expenses and makes such changes retroactive, the Plan will not make payment for retroactive Incurred expenses. The Plan will not seek refunds for it previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network Provider - See In-Network Provider.

Newborn is an infant from the date of birth until the initial Hospital discharge or until the infant is 14 days old, whichever comes first.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Non-Preferred Brand Name Drugs are Brand Name Drugs not listed on the preferred Formulary drug list supplied separately by the Pharmacy Benefit Claims Administrator.

Orthotics is an external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

Out-of-Network Provider is an organization, Physician, Hospital, Pharmacy or other Professional Healthcare Provider that, at the time Covered Services or Supplies are provided, does not have a contract or agreement with the Participating Provider Network selected by the Plan to provide medical Services or Supplies to the Covered Persons under the Plan for scheduled or negotiated charges or allowances.

Out-of-Pocket means the patient liability portion of the Percentage Coinsurance.

Outpatient is care given in the Outpatient or emergency department of a Hospital or other health facility, or care given in the Provider's office, patient's home, or other care given on other than an Inpatient confinement basis.

Partial Hospitalization is an Outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a Psychiatric Facility or Substance Use Disorder Facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for Room and Board.

Participating School is any one of the schools comprising the Jefferson-Lewis et. al. Schools alliance that has agreed to sponsor this self-funded Plan for its eligible Enrollees.

Participation Contribution are the Plan participation costs that the Participating School collects from its Plan Enrollees.

Percentage Coinsurance is that figure shown as a percentage used to compute the benefits payable of Allowed Charges. The Covered Person is responsible for the payment of the Coinsurance reduction amounts.

Pharmacy means a licensed establishment where Covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), licensed clinical psychologist (PhD.) or licensed clinical social worker (for care of Mental Disorders), licensed dentist or dental surgeon operating within the scope of such license for Covered health/dental Services, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Jefferson-Lewis et. al. School Employees' Healthcare Plan, which is a benefits Plan for certain active Employees and Retired Employees of the Participating Schools and is described in this document.

Plan Administrator is the collective body, called the Board of Trustees, consisting of one representative from each of the Participating Schools in the Plan.

Plan Participant is any Employee, Retiree or Dependent who is Covered under this Plan.

Plan Sponsor is the Participating Schools who make this Plan available to its Employees and Retirees in accordance with the Plan provisions.

Plan Year is the 12-month period beginning on either the Effective Date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Preferred Brand Name Drugs are Brand Name Drugs listed on the preferred Formulary drug list supplied separately by the Pharmacy Benefit Claims Administrator.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Professional Healthcare Provider is a person who is licensed under New York State Law to render or prescribe Covered Services or Supplies under the Plan and is operating within the restrictions or scope of that license. Outside New York State, licensed Professional Healthcare Providers will be Covered to the extent that they would otherwise have been Covered if operating in New York State. In this case, the Provider must be licensed in the state of jurisdiction and rendering Plan Covered Services or Supplies within the scope of that license (and scope of similar New York license).

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, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider - Any legally licensed Physician, licensed nurse midwife (for maternity care), optometrist and optician (for vision care), physical therapist, speech therapist, licensed clinical social worker (for Mental Disorder care), licensed independent laboratory, Pharmacy, Hospital, Skilled Nursing Facility, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan Coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for Covered Services given by Covered Physicians or other healthcare Providers that would otherwise be Covered by the Plan. Also, see definitions for certain Providers. To be Covered, a Provider must meet Plan definitions and

limitations, render a Covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where Services and/or Supplies are given or delivered.

Psychiatric Facility is a facility established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located to provide Inpatient and/or Outpatient psychiatric or Mental Disorder care. The facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for Inpatient Mental Disorder care or by a state owned Inpatient or Outpatient Psychiatric Facility that usually bills for its Services.

Rehabilitation Facility - See Skilled Nursing Facility.

Retired Employee or Retiree is a person who was actively employed by the Employer when retired and eligible for Plan continuation under the established written retirement program of the Participating School; and who elects to continue Plan Coverage and pays the required Retiree Participation Contributions.

Room and Board are all charges by whatever name called that are made by the Hospital, Skilled Nursing Facility, or other Inpatient medical facility as a condition of occupancy. Such charges do not include professional Services by Physicians or for intensive private nursing, by whatever name called.

Routine Newborn Nursery Care are charges made by the caring Hospital or similar institution and/or the attending Physician for the Custodial and nursing care, including circumcision, of a Newborn infant deemed to be free of any identifiable Illness or disease requiring treatment.

Services or Supplies - See Covered Services or Supplies.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing Services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its Services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24-hour per day nursing Services by licensed nurses, under the direction of a full-time registered nurse.

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

(5) It has an effective utilization review Plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare as a participating facility eligible for Medicare Part A Inpatient Skilled Nursing Facility benefits and is 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 or a national accreditation organization recognized by the Claims Administrator.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

Spell of Illness is a period beginning with the first allowable care for treatment of any Illness or Injury as an Inpatient in a Hospital, Substance Use Disorder Facility, Skilled Nursing Facility, Birthing Center or Home Health Care Agency for services in lieu of hospitalization, and ending when, for a period of at least 90 days of Continuous Confinement or re-Confinement in a Hospital, Skilled Nursing Facility, Birthing Center or Home Health Care Agency for services in lieu of hospitalization has not occurred. A Confinement for an accident shall not be combined with another Confinement for an Illness in determining Spell of Illness. If discharged from one facility and admitted to another facility on the same day, only one day will be counted.

Spouse is a person who is the legal husband or wife of an eligible Employee or Retiree who meets the eligibility requirements as set forth in the section entitled "Eligibility, Funding, Enrollment, Effective Date and Termination" shown previously in this document.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Use Disorder Facility is an agency, clinic 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 Inpatient or for Outpatient treatment of Substance Use Disorder (drugs and/or alcohol), and acting within the scope of such license and accreditation. For Services given 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 Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment and diagnosis of Substance Use Disorder.

Supplies are any drugs, medicines, devices, appliances, equipment, braces, casts, Prosthetics, materials, or other items used for medical care.

Surgery is any of the following:

(1) To incise, excise or electocauterize an organ or body part;

(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 if deemed such under the current Physicians' Current Procedural Terminology (CPT) published by the American Medical Association.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability (Totally Disabled) means the following:

(1) In the case of the Employee, the complete inability as a result of Injury or Sickness to perform the substantial and material duties of such Employee's regular employment, or engage in a similar occupation for which the person is reasonably suited by reason of education, experience or training.

(2) In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex who is in good health.

Urgent Care Facility is a legally operated emergency clinic or center that meets the requirements in the jurisdiction of license to provide Outpatient emergency medical care or emergency minor Surgery. It must be a facility that is primarily engaged in providing minor emergency and episodic care to a Covered Person. A qualified Physician, a registered nurse and a registered X-ray technician must be in attendance at all times that the clinic is open. The center must have on the premises, X-ray and lab equipment and a life support system. A clinic, center, or facility meeting these requirements will be considered an Urgent Care Facility by whatever actual name it is called.

Usual, Reasonable and Customary Charge (URC) is the lowest of:

(1) The actual charge for the Service or Supply;

(2) The usual charge by the doctor or other Providers 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) using percentiles of current fee data profiles.

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 necessary to obtain a representative cross section of level charges. The part of the cost that exceeds this amount for any 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 usual, reasonable or customary charges. The Claims Administrator makes the determination of the Usual, Reasonable and Customary Charges for a Service or Supply. The determination of URC charges could be different for the Traditional Option and the Provider Choice Option based on their respective use of different percentiles.

Waiting Period is the designated period between the Employee's date of eligible employment and the date the Employee becomes Covered for Plan benefits.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in Prescription Drug Benefits.

All exclusions related to the Vision Care Benefit (Provider Choice Option only) are shown in Vision Care Benefits.

For all Medical Benefits shown in the "Schedule of Benefits", a charge for the following is not covered:

(1) **Abortion.** Services, Supplies, care or treatment in connection with an induced or elective abortion or other termination of Pregnancy unless documented evidence is presented showing the Medical Necessity for the termination of the Pregnancy.

(2) **Anesthesia.** Services or Supplies for the administration of Anesthesia for any Surgery or treatment that is not Covered by the Plan.

(3) **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory No-Fault or fault Automobile Insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for Services or Supplies not paid by the No-Fault or automobile insurance coverage due to its deductible or maximum payment limits will be Covered under this Plan to the extent Allowed Charges would have otherwise been payable by this Plan. **Note:** No-Fault and motor vehicle liability coverage is considered another plan under the "Coordination of Benefits" provision of this Plan.

(4) **Blood Donations.** Services or Supplies for autologous or direct blood donations and storage when done as precautionary measures in case the need for blood arises. **Exception:** Autologous or direct donation Services or Supplies preceding Surgery that could require blood transfusion as specifically included in the Plan.

(5) **Cosmetic.** Services or Supplies connected with elective cosmetic Surgery or treatment. Procedures that may be used to treat a medical condition in addition to improving ones appearance will be reviewed for Medical Necessity. Reversal of elective, cosmetic Surgery will not be Covered unless found to be Medically Necessary according to Plan provisions. **Exception:** Care required to significantly restore tissue damaged by an Illness or Injury 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.

(6) **Counseling/Analysis/Support Groups.** Services or Supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups. **Exception:** Family counseling specifically included for Coverage under Outpatient Substance Use Disorder or Hospice Care.

(7) **Custodial Care.** Services or Supplies provided mainly as a rest cure, maintenance or Custodial Care. Services or Supplies given in a place of rest, a place for the aged, a nursing home or an educational facility, a place mainly for the care of alcoholism, drug addiction, Mental Disorders or tuberculosis except facilities that meet Plan requirements for Skilled Nursing Facility; Psychiatric Facility and Substance Use Disorder Facility benefits. Long term or non-acute care that cannot reasonably be expected to lessen the patient's disability enabling him or her to leave an institution is excluded. **Exception:** Hospice care Services specifically included for Plan Coverage.

(8) Dental Care. Services or Supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other Services considered to be dental, rather than medical, in nature. Adjustments, Services, appliances or Supplies related to treatment for Temporomandibular Joint disorders (TMJ) or similar disorders that is dental in nature. We do not consider damage to Sound Natural Teeth caused directly or indirectly by biting or chewing to be considered an Accidental Injury. **Exception:** Charges by a dentist or Physician for care otherwise considered medical care 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, treatment and Surgery for joint disorders, freeing of muscle attachments or for care given for Accidental Injury to Sound Natural Teeth within 12 months following the accident and treatment found Medically Necessary due to congenital disease or anomaly.

(9) Drugs/Infertility/Vitamins/Supplements. Medicines or drugs that can be purchased without a Physician's prescription; Infertility drugs for persons under age 21 or older than age 44; or vitamins and supplements, including nutritional supplements or food products, whether or not obtainable by prescription. **Exceptions:** Diabetic drugs and Supplies as specifically shown as Covered under Plan provisions. Prenatal prescription vitamins, certain aminoacidopathies formula, enteral formula or modified food products specifically shown as Covered under section entitled "Prescription Drug Benefits". For Covered Persons, of any age, the Plan covers prescription Infertility drugs used for treatment of other correctable medical conditions Covered by the Plan even if that condition resulted in Infertility.

(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, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase 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 that are primarily for athletic use. Personal, household, or environmental items (examples- pillows, blankets, mattresses, exercise equipment, air-conditioners, air purifiers, and non-Hospital adjustable beds).

(11) Educational/Cognitive/Training/Therapy for Developmental/Birth Defects. Services or Supplies related to special education, training, vocational training 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, 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 or Supplies that are provided by any school system, under any law, unless the law makes this Plan primary for the expenses otherwise Covered by the Plan. This applies even if the Covered Person, parent or guardian does not seek provision of such Services or Supplies through the school system. **Exception:** The diagnosis and treatment of autism spectrum disorder (which means a neurobiological condition that includes autism, Asperger Syndrome, Rett's syndrome, or pervasive developmental disorder) is covered.

(12) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual, Reasonable, and Customary Charges according to Plan provisions.

(13) Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy Covered by this Plan.

(14) Experimental or not Medically Necessary. Care and treatment that is either considered Experimental/Investigational or not Medically Necessary according to Plan provisions. **Exception:** where the insurance law of the State of New York mandates Coverage for any drug prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, but is recognized as appropriate treatment for the specific type of cancer in one of the following established reference compendia:

(a) National Comprehensive Cancer Networks Drugs and Biologics Compendium;

(b) the American Hospital Formulary Service-Drug Information(AHFS-DI);

(c) Thomas Micromedex DrugDex;

(d) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

(15) Eye care. Routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Procedures to replace the need for eyeglasses or contacts unless found Medically Necessary. **Exceptions**: Services specifically included in the Plan such as initial contacts or glasses following cataract or other intraocular Surgery, lenses for aphakia and soft lenses or sclera shells intended for treatment of disease or Injury; Services or Supplies shown under "Vision Care Benefits" for the Provider Choice Option.

(16) Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(17) Foreign travel. Care, treatment or Supplies out of the USA, except Canada and Mexico, if travel is for the sole purpose of obtaining medical Services.

(18) Government Coverage. Care, treatment or Supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(19) 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 acute care Hospital or Skilled Nursing Facility that customarily bills for its Services.

(c) State or local government owned mental health facility.

(d) Government owned facility that otherwise meets Plan limitations for Coverage as an Outpatient alcohol or Substance Use Disorder treatment facility.

(e) USA military acute care 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.

(20) Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(21) Hearing. Services or Supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. **Exceptions:** The initial hearing aid for hearing loss caused by a Covered surgical procedure rendered to a patient while he is Covered under the Plan; Services Covered under the well adult or well child sections of this Plan. Provider Choice Option only, Medically Necessary hearing aids, related exams and fittings up to the benefit limits specifically included as Covered Charges.

(22) Home Medical Supplies. Medical Supplies for home use that are not directly supplied by professional home care Services during an Approved Plan of Home Care, or that are not for the operation of Covered Durable Medical Equipment unless otherwise specifically included for Coverage. Items primarily intended for comfort or to support activities of daily living, such as diapers, ice bags, incontinent pants, nutritional supplements, cervical or lumbar pillows. **Exception:** Diabetic medical Supplies; ostomy Supplies; catheter Supplies; extensive dressings; and Supplies approved for home kidney dialysis specifically shown as Covered under Plan provisions.

(23) Hospital/facility Employees. Professional Services billed by a Physician or nurse who is an employee of a Hospital, or Skilled Nursing Facility, or any Inpatient facility where care is received and the Hospital/facility employee is paid by the Hospital or facility for the service. **Exception:** Hospitalists, and Physician Extenders who have contracts for payment with the Claims Administrator.

(24) Illegal acts. Charges for Services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(25) Illegal care. Services or Supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded Services are obtained outside the USA even if these Services are legal in the foreign country.

(26) Implants. Claims for implants billed by a facility may be denied unless they are submitted with the invoice.

(27) Infertility/Reproduction/In-vitro. Services or Supplies related to reproduction, in-vitro fertilization procedures or other artificial conception procedures as specifically excluded by the New York State Insurance Department regulations. Services or Supplies relating to treatment of Incurred for persons under age 21 years or older than age 44. **Exception**: For Covered Persons, any age, Plan covers treatment of other correctable medical conditions even if that condition resulted in Infertility. Documentation of correctable medical conditions must be presented to the Claims Administrator.

(28) Late Claim Filing. Services or Supplies for which an adequate claim is not filed with the Claims Administrator within the Plan time limits for claim submissions. Claims must be submitted by March 31 of the Calendar Year following the end of the Calendar Year in which the Covered Services were Incurred to be eligible for benefits. **Exception:** 90 day extension for Medicare and other health plan delays shown under the section entitled “How to Submit a Claim”, subsection entitled “When Claims Should Be Filed” shown later in this document. Other exceptions may be made by the Claims Administrator or the Plan Administrator for late claim filing due to extenuating circumstances beyond the control of the Enrollee.

(29) Medical Necessity. Services or Supplies that are not Medically Necessary according to Plan provisions for the treatment of the Illness or Injury (examples- preventive care or well care such as routine physicals, screening exams, premarital exams, school exams, sport exams, and related Services; precautionary Services, standby Services even if ordered by the doctor or due to Hospital regulations). **Exception:** Expenses connected with voluntary sterilization (but not the reversal of), limited preventative care or child immunizations and other expenses specifically included in the Plan.

(30) Midwife/Doctor Duplicate Services. Services that are duplicative because they are provided by both a nurse midwife and doctor.

(31) 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.

(32) Missed Appointments/Phone Consultations/Forms/No Care Given. Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby Services. Services or Supplies not actually received by the patient or Incurred by someone other than the patient unless specifically included in this Plan such as Coverage limits for organ donors.

(33) No charge/No obligation to pay. Care and treatment for which there would not have been a charge if no Coverage had been in force or for which there is no legal obligation for payment by the Enrollee or the Dependent. **Exception:** Coverage to the extent federal and state law requires the Plan to allow benefits that would have been otherwise payable.

(34) No Physician recommendation. Care, treatment, Services or Supplies not recommended and approved by a Physician; or treatment, Services or Supplies when the Covered Person is not under the regular care of a Physician or other attending Professional Healthcare Provider authorized by New York State law to prescribe such Services or Supplies. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(35) Not specified as Covered. Non-traditional medical Services, treatments and Supplies (e.g., alternative medicine, acupuncture) which are not specified as Covered under this Plan.

(36) Occupational Conditions/Work Related. Services or Supplies provided under any State or Federal worker's compensation, employer's liability or occupational disease law due to an occupational Injury or occupational Illness as set forth in Article 11 NYCRR.§ 52.16 (c) (8).

(37) Orthotics (foot). Charges in connection with foot Orthotics that are not Medically Necessary (used to treat misalignment of the feet, routine conditions or for sports).

(38) 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 benefit management or managed care program, preadmission review, second surgical opinion, or any other reason, including failure to abide by the primary care Physician network established by a health maintenance organization that is a primary plan payer.

(39) Personal comfort items. Personal comfort items or other equipment (examples- air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, non-Prescription Drugs and medicines, first-aid Supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber Services charged by any facility or other Provider).

(40) Plan design excludes. Charges excluded by the Plan design as specified in this document.

(41) Private Duty Nursing. Outpatient or Inpatient private duty or personal nursing Services by a registered professional nurse, licensed practical nurse or other medical professional whether or not ordered by a Physician. **Exception:** Part-time nursing that is part of an Approved Plan of Care and Covered under Home Health Care and Hospice benefits, nursing assessments ordered through the Cost Management Program or care that is part of an Approved Plan of case management under the Cost Management Program.

(42) Prohibited Referral. Any Pharmacy Services, clinical laboratory, X-ray or imaging Services which were provided pursuant to a referral prohibited by the New York State Public Health Law or similar laws in other states, if service is rendered out of New York.

(43) Relative or self giving professional Services. Professional Services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as an Immediate Relative, whether the relationship is by blood or exists in law.

(44) Reversal Sterilization Procedures. Services or Supplies related to the reversal of sterilization procedures, whatever the reason.

(45) Room and Board. Room and Board charges in any facility during a period when the Covered Person (patient) is not physically present. Private room charges more than the facility Average Semi-Private Room Rate unless the use of the private room has been ordered by the attending Physician and found Medically Necessary for the care of the patient. **Exception:** Up to $10 for non-Medically Necessary private room charges over the Average Semi-Private Room Rate as specifically included for the Traditional Plan Option only.

(46) Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or Services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically Covered in the "Schedule of Benefits" and included in the Plan.

(47) Self-Inflicted. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(48) Services before or after Coverage. Care, treatment or Supplies for which a charge was Incurred before a person was Covered under this Plan or after Coverage ceased under this Plan unless extension of Coverage due to Total Disability applies.

(49) Sex changes. Unless Medically Necessary care, Services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment.

(50) Subrogation/Third Party Claim. New York General Obligations Law (GOL) § 5-335 provides that a right of subrogation does not apply when a settlement is reached between a plaintiff and defendant except where there is a statutory right of reimbursement. It further provides that by entering into such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any non-statutory right of any benefit provider that paid medical expenses; nor does a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider. In addition, GOL § 5-335 sets forth the presumption that a settlement between a plaintiff and defendant does not include compensation for the cost of health care services to the extent those expenses are paid or reimbursed by a benefit provider.

(51) Surrogate Pregnancy. Services or Supplies related to surrogate maternity care (examples- services or Supplies needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy). Benefits are available for Newborns who meet the child eligibility requirements and who are enrolled under family Coverage, For Covered Persons acting as a surrogate, pre-and post-natal care and delivery services will be covered in the same manner as any other Pregnancy.

(52) Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as listed as a Covered Charge.

(53) War/Riot. Any loss that is due to a declared or undeclared act of war or due to participation in a civil insurrection or riot.

(54) Weight Loss or Dietary Control. Care and treatment of weight loss or dietary control whether or not it is, in any case, a part of the treatment Plan for another Sickness. **Exception:** Coverage specifically shown in the Plan for diabetic education and Medically Necessary services (which are subject to the same utilization review and external appeal rights under article 49 as any other service).

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Prescription Drug Benefits are separate from Medical Benefits and do not apply to the Deductibles, Copayments or Out-of-Pocket limits for Medical Benefits.

Network Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for Covered Prescription Drugs. CVS/Caremark is the Claims Administrator of the Pharmacy Drug Plan.

You and your Covered Dependents may purchase drugs from any Pharmacy. However, if this Plan is considered the primary payer under the Coordination of Benefit provision and you and your Covered Dependent choose a CVS/Caremark Network Retail Pharmacy or mail order Pharmacy for your maintenance drugs, you save costs for yourself and your Employer. If this Plan is primary, Prescription Drug Benefits are separate from Medical Benefits and do not count towards the medical Deductible or Out-of–Pocket limits of the Medical Plan.

If this Plan is not considered the primary payer under the Coordination of Benefit provision then Prescription Drug Benefits are not available through CVS/Caremark. Prescription Drug Benefits are available under Medical Benefits as is shown in the section entitled “Schedule of Benefits” shown previously in this document. Medical Deductible, and Out-of–Pocket limits do not apply. All benefit limitations and exclusions apply as shown in this section entitled “Prescription Drug Benefits”. Plan benefits are coordinated with the primary plan’s benefits.

COPAYMENTS

The Copayment is applied to each Covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The Copayment amount is not a Covered Charge under the Medical Plan. Any one Pharmacy prescription is limited to a 34-day supply or 100- dosage unit, whichever is greater. Any one mail order prescription is limited to a 90-day supply.

PREAUTHORIZATION REQUIREMENTS

Some drugs or devices require pre-authorization before drug benefits become available. The Network or mail order Pharmacy will not provide Coverage unless the drugs have been approved for benefit payment. If a Pharmacy advises you that you need pre-authorization, a letter of Medical Necessity from your attending Physician should be sent to the Clinical Department at POMCO (POMCO reviews Medical Necessity for CVS/Caremark). You or your Physician may also call CVS/Caremark to confirm whether or not a drug requires pre-authorization. Letters of pre-authorization can be mailed to the following address:

POMCO Clinical Department
PO Box 6329
Syracuse, NY 13217
Fax: 1-315-463-1483
Phone: 1-800-581-5300 CVS/Caremark or
1-800-836-0709 POMCO Clinical Department

Benefits will become available or be denied based on the review of the Clinical Department. The following is the list of drug types that currently require pre-authorization:

Infertility/fertility drugs for Covered Persons under age 21 and older than age 44.
Aminoacidopathies Formula; Enteral Formula and Modified Food products (normal nutritional supplements or elective supplements are not Covered).
Growth hormones.
Lovenex.
Biotech drugs (example Capaxone).
Insulin pumps.

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 replacements, ask for advice from your Physician or pharmacist.

PREFERRED/NON-PREFERRED BRAND NAME DRUGS

Preferred Brand Name Drugs are drugs listed on the CVS/Caremark Formulary drug list. Brand Name Drugs not listed are considered non-Preferred Brand Name Drugs and are subject to a higher Copayment. The Formulary drug list is provided separately by CVS/Caremark and may be updated periodically. For details and a current list of Formulary medications, please contact CVS/Caremark at 1-800-581-5300, or on their website at www.caremark.com.

NETWORK PHARMACY

A Network Pharmacy has an agreement with the Prescription Drug Claims Administrator, CVS/Caremark to accept Plan benefits, after any applicable Copayment, as payment in full. If this Plan is primary, you or your Dependents may purchase drugs at CVS/Caremark Network Pharmacies. You will be required to pay only the applicable Copayments. If this Plan is not primary, then Pharmacy Drug benefits through CVS/Caremark are not available, do not obtain benefits through CVS/Caremark. Refer to the subsection entitled "When Another Plan is Primary" later in this section for details.

To obtain Network Pharmacy benefits:

(1) You can show your Plan identification card at any CVS/Caremark Network Pharmacy. The Pharmacy may display the CVS/Caremark participation logo or you may ask the Pharmacy if they participate as a CVS/Caremark Network Pharmacy. You can also phone CVS/Caremark at 1-800-581-5300 for Network Pharmacy information.

(2) To obtain your Covered drug or supply at network cost, you need only present your Plan identification card and the written prescription to the CVS/Caremark Network pharmacist, then pay the applicable Copayment amount as shown in the "Schedule of Benefits". The Pharmacy will bill CVS/Caremark directly and will receive direct payment from them. If you do not present your Plan identification card at the time of purchase, you must purchase the drug in full and file your own claim with CVS/Caremark. Benefits will be allowed as if the drug was purchased at an Out-of-Network Pharmacy.

Questions or concerns about the Network Pharmacy drug program can be answered by CVS/Caremark. You may contact them by calling their customer service department during normal operating hours or send a written inquiry to:

CVS/Caremark
620 Epsilon Drive
Pittsburgh, PA 15238-2845
Phone: 1-800-581-5300

OUT-OF-NETWORK PHARMACY

If this Plan is primary and you or your Covered Dependents purchased Covered drugs at an Out-of-Network Pharmacy (or do not use your Plan identification card), you must pay the Pharmacy and submit a claim for benefits to CVS/Caremark. Benefits will be based on the Usual, Reasonable and Customary (URC) Charges for the Covered drugs less the applicable Copayment amount. Refer to the "Schedule of Benefits" for Copayment amounts. You will be responsible for payment of charges more than the URC allowance. To file a claim for benefits, you must obtain a drug claim form from your Participating School healthcare clerk or from CVS/Caremark. The original drug receipt (receipt should include dates of purchase, name of drug, dose and prescription number) and the completed drug claim form should be mailed to:

CVS/Caremark
620 Epsilon Drive
Pittsburgh, PA 15238-2845

If this Plan is not primary then Pharmacy Drug benefits through CVS/Caremark are not available; do not obtain through CVS/Caremark. Refer to the subsection entitled "When Another Plan is Primary" later in this section for details.

MAIL ORDER DRUG BENEFIT OPTION

If this Plan is primary, the mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). In addition, acute care medications with prescriptions written for more than 21 days (one refill) may be obtained through the mail order option. Because of volume buying, CVS/Caremark, the mail order Pharmacy, is able to offer Covered Persons significant savings on their prescriptions. CVS/Caremark will bill the Plan directly. You will be responsible for the applicable Copayment as listed in the "Schedule of Benefits".

To obtain Mail Order Pharmacy benefits:

(1) When your doctor writes a prescription for a "maintenance drug" (one taken regularly or on a long term basis) ask him or her to indicate the number of refills allowed.

(2) For your first mail order service, complete a patient profile/registration form (obtained from your Participating School's healthcare clerk). Enclose the completed form in the self- addressed envelope with the original prescriptions written by your doctor and mail to CVS/Caremark.

(3) For original and refill prescriptions, complete the supplied order form. A new order form and envelope will be included with each delivery. You may also order refills over the internet at www.caremark.com.

(4) Your medication will be delivered to you by first-class mail or UPS. You should allow 10-14 days from the time you mail your prescription forms to CVS/Caremark until the delivery of your medication. However, to best ensure that you do not leave yourself without an adequate supply of medication, you will be best protected if you order when you have a minimum of a three-week supply of your current medication.

CVS/Caremark
PO Box 419096
Kansas City, MO 64179-0844
For refills you may: phone 1-800-222-3383 or website www.caremark.com

If this Plan is not primary, then Pharmacy Drug benefits through CVS/Caremark are not available; do not obtain benefits through CVS/Caremark. Refer to the subsection entitled "When Another Plan is Primary" later in this section for details.

WHEN ANOTHER PLAN IS PRIMARY

When another plan is considered primary coverage according to the COB order of benefit determination, you must obtain prescription benefits through the primary plan first, then file a claim with POMCO (not CVS/Caremark). Benefits will be paid under Medical Benefits. Refer to Medical Benefits shown previously in this document for details; Prescription Drug Benefits through CVS/Caremark are not available. However, all benefit drug limitations and exclusions apply as noted in this section.

If this Plan is secondary do not show your Jefferson-Lewis et. al. Schools Employee Healthcare Plan identification card at the time of purchase. Claims should first be submitted to the primary plan and then you may obtain a POMCO claim form from your Participating School healthcare clerk or from POMCO. Complete the claim form and attach your original Prescription Drug receipt (receipt should include dates of purchase, name of drug, dose and RX#) and a copy of the primary plan's explanation of benefits and mail to POMCO.

COVERED PRESCRIPTION DRUGS

(1) Medications that require a written prescription by a legally authorized Licensed Healthcare Provider and are federal legend drugs, but excludes any drugs stated as not Covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Prenatal prescription vitamins when taken during Pregnancy, Vitamin B-12 when ordered due to pernicious anemia, other single entry vitamins are excluded.

(4) Prescription contraceptive drugs or devices.

(5) Prescription Drugs used in the treatment of Infertility for persons age 21-44 years old (if under age 21 or older than age 44, Infertility drug must be used to treat a correctable condition otherwise Covered by the Plan and not for reproduction or birth control purposes - requires pre-authorization).

(6) Hematological agents (folic acid or iron).

(7) Diabetic insulin or oral agents for controlling blood sugar, hypoglycemic rescue agents, testing agents, lancet auto injectors, lancets, insulin auto injectors and needles, glucose monitoring machines, insulin pumps and related Supplies.

(8) Injection delivery devices (syringes) for use other than diabetic when necessary for self-administration of Covered injection legend drugs.

(9) Smoking deterrents (patches, gum and pills) obtained with a prescription (90-days maximum per Lifetime).

(10) Aminoacidopathies Formula/Enteral Formula/Modified Solid Food Products. Limited Coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a Physician, or other licensed healthcare Provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders. Plan Coverage is limited to the following:

> **(a)** Aminoacidopathies Formula. Certain nutritional supplements (formulas) are Covered when found Medically Necessary for the therapeutic treatment of the following aminoacidopathies (disorders that prevent the body from properly digesting amino acids): phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. Coverage is not available for nutritional supplements taken electively.
>
> **(b)** Enteral Formulas. The prescribing healthcare Provider must state in writing that the enteral formula is clearly Medically Necessary and has been proven effective as the disease-specific regimen for those individuals who are or will become malnourished or who suffer from disorders, which left untreated, cause chronic disability, mental retardation or death. These

specific diseases include, but are not limited to, aminoacidopathies, gastric motility disorders such as chronic intestinal pseudo-obstruction and multiple severe food allergies that if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death. Coverage is not available for nutritional supplements taken electively.

(c) Modified Solid Food Products. Coverage is available for modified solid food products that are low protein, or which contain modified proteins that are Medically Necessary for certain inherited diseases of amino acid and organic acid metabolism**. Allowable Fees for Covered modified solid food products are limited to $2,500 per Calendar Year.** Coverage is not available for nutritional supplements taken electively.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a Covered Prescription Drug charge. The Covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a Covered Prescription Drug.

(2) **Appetite suppressants-anti-obesity drugs/dietary/food supplements/vitamin supplements.** Any charge for appetite suppressants, anti-obesity drugs, dietary supplements, food supplements or vitamin supplements, obtainable with or without a prescription, unless otherwise found Medically Necessary.

(3) **Consumed on premises.** Drugs or Supplies furnished by a Home Health Care Agency, Hospice Care Agency or by Hospitals, Skilled Nursing Facilities, Rehabilitation Facilities or other facilities while the patient is Confined. These drugs and Supplies are considered part of the Services provided by the facility and are not Covered under the Prescription Drug Benefits. Drugs dispensed while the Covered Person is considered a resident in a nursing home or other residential facility will be considered only when the patient is billed separately by the Pharmacy.

(4) **Cosmetic.** Any drug or medication used for preserving or promoting appearance.

(5) **Devices.** Devices of any type, even though such devices may require a prescription, These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. **Exception:** Contraceptive and diabetic devices as specifically shown as Covered under the Plan.

(6) **Experimental.** Experimental drugs and medicines or drugs prescribed for Investigational (non-FDA approved/unlabeled) indications, even though a charge is made to the Covered Person. **Exception for Cancer Drugs only:** In accordance with New York State Law, the State of New York mandates Coverage for any drug prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, but is recognized as appropriate treatment for the specific type of cancer in one of the following established reference compendia:

(a) National Comprehensive Cancer Networks Drugs and Biologics Compendium;

(b) the American Hospital Formulary Service-Drug Information(AHFS-DI);

(c) Thomas Micromedex DrugDex;

(d) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

Benefits will also be provided for Experimental drugs and medicines if required pursuant to an external appeal.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Fluoride prep and dental rinses.**

(9) **Growth hormones.** Growth hormones are excluded unless pre-authorized.

(10) **Immunization.** Immunization agents, vaccines, allergy extracts or biological sera.

(11) **Infertility or fertility medications for persons under age 21 or older than age 44. Exception:** For Covered Persons, any age, Plan covers prescription Infertility drugs used for the treatment of other correctable medical conditions Covered by the Plan even if that condition results in Infertility.

(12) **Medical exclusions.** Medical exclusions are the exclusions listed in the Section of this document entitled Plan Exclusions and apply to Prescription Drug charges.

(13) **No charge.** Any charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(14) **No prescription.** Any drug or medicine that can legally be bought without a written prescription is not Covered. **Exception:** This does not apply to injectable insulin or other drugs specifically included for Coverage under this benefit.

(15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

VISION CARE BENEFITS (PROVIDER CHOICE OPTION ONLY)

Vision Care Benefits are available for routine vision Services only. These claims are administered by the vision care Claims Administrator, Davis Vision. Vision Care Benefits are separate from Medical Benefits and do not count towards the medical Deductible or Out-of-Pocket limit. Benefits are limited to once every two Calendar Years for each Covered Person.

Vision Care Benefits apply when vision care charges are Incurred by a Covered Person for Services that are recommended and approved by a Physician or Optometrist for routine vision Services only. Should an Enrollee require eye care due to an Illness or Injury, Coverage is available under the section entitled "Medical Benefits" shown previously in this document.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Allowed Charges for the vision care Services and Supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care Service or Supply.

LIMITS

Covered Services or Supplies are limited to one eye exam and one pair of eyeglasses or one pair of contact lenses, in lieu of eyeglasses, in any two Calendar Years for any combination of In-Network and Out-of-Network Services.

NETWORK VISION CARE PROVIDER

The Network Vision Care Provider has an agreement with Davis Vision to accept scheduled benefits as payment in full for identified frames, lenses or contact lenses (Plan selection). The Network Provider will assist the Covered Person on their selection of Covered Services or Supplies and will show the Covered Person what is available at Network costs. If an out of Plan selection is chosen, you will be required to pay the costs that are more than the Network allowance and any applicable Copayments. Please refer to the section entitled "Schedule of Benefits" shown previously in this document for applicable Copayment amounts.

(1) Covered Services and Benefits

Eye Exam Copayment applies, then balance of Network allowance is paid in full.

Lenses 100% of Network Allowance for Plan selection single vision, bifocal or trifocal lenses. (You pay additional costs for choices outside the Plan selection.)

Frames 100% of Network Allowance from Plan selection frames. (You pay additional costs for choices outside the Plan selection.)

Contact Lenses Copayment applies, then balance of Network allowance is paid in full for standard, soft daily wear contact lenses in lieu of glasses. (You pay additional costs for choices outside the Plan selection.) Copayment applies for the initial supply of disposable/planned replacement contact lenses in lieu of eyeglasses. This is approximately a three to six month's supply dependent on person's wearing habits. (You pay the costs for subsequent purchases during the same two Calendar Year period.)

An Enrollee is required to pay any additional charges for contact lens fitting and recommended follow-up care. Once the contact lens option has been selected and the lenses are fitted, they may not be exchanged for eyeglasses. Once you select standard soft lenses, you will not be reimbursed for disposable contacts, nor if you select disposable contacts can you later exchange them for soft contact lenses. Only one pair of lenses or one pair of eyeglasses is payable during any two Calendar Years.

(2) Network Providers/Out of Plan Discounts. Davis Vision Network Providers offer discounted fees for certain optional items not included as Covered Services or Supplies in this Plan. Davis Vision also offers mail order replacement contact lens service. This Plan does not provide benefits for these Services. The Enrollee must pay the charges directly to the Provider at the time the service is rendered. Davis Vision will send information on these special discounts when they receive confirmation of your enrollment in the Provider Choice Option. You may also contact them at:

Vision Care Plan
Quality Management Team
159 Express Street
Plainview, NY 11803-2404
Phone: 1-800-999-5431

OUT-OF-NETWORK VISION CARE PROVIDER

If Covered vision care Services are obtained from an Out-of-Network Provider, you must pay the Provider, then submit a claim to Davis Vision. Covered Services or Supplies will be based on the same rules as Network Covered Services or Supplies. However, Out-of-Network benefits will be limited to the Services and scheduled allowances shown in the section entitled "Schedule of Benefits" shown previously in this document.

Only one exam and one pair of eyeglasses or one pair of contact lenses (in lieu of eyeglasses) are Covered in any two Calendar Years for any combination of In-Network and Out-of-Network Services. No other Services are Covered under this benefit.

HOW TO OBTAIN SERVICES OR BENEFITS

(1) Network Providers. Davis Vision will mail a Network Provider list of area vision care Providers to Enrollees after they receive notice of your Provider Choice Option enrollment. To obtain vision care Services from a Network Provider, you or your Dependent must first call the Provider to schedule an appointment. You or your Dependent should be prepared to give the Network Provider the Enrollee Member ID number, shown on your Plan identification card. The Network Provider is responsible for obtaining any necessary information confirming eligibility for benefits. Covered Persons can also verify eligibility or locate a Network Provider in the area by calling, toll free 1-800-999-5431.

If you or your Dependent decide to use a different Network Provider after scheduling an appointment, a phone call should be made to Davis Vision at 1-800-999-5431 for further instructions.

The Network Provider will bill Davis Vision for the Plan selections and receive payment from them. You will be responsible for the payment of applicable Copayments and additional charges for choices outside the Plan selections when Services are given.

(2) Out-of-Network Vision Care Provider. If the Enrollee or Dependent obtains vision care Services from an Out-of-Network Provider, the Enrollee must pay the Provider at the time Services are given, then submit a claim to Davis Vision.

Before the appointment with the Out-of-Network Provider, you or your Dependent should call Davis Vision at their toll-free number to request a claim form. The claim form should be completed by the Provider and you, as applicable. Then you should attach an itemized receipt and mail the completed

form to Davis Vision at the address shown below. Davis Vision will advise you of their benefit determination by mail. Available benefits will be paid to you.

Davis Vision
Vision Care Processing Unit
PO Box 2270
Schenectady, NY 12301
Phone 1-800-999-5431

VISION CARE INQUIRIES

If you or your Dependent need verification of eligibility, or a location of Network Providers, or have any other questions concerning this benefit, you may write or call Davis Vision at the following address or phone number:

Vision Care Plan
Quality Management Team
159 Express Street
Plainview, NY 11803-2404
Phone 1-800-999-5431

VISION CARE BENEFIT EXCLUSIONS

No benefits will be payable for the following:

(1) Before Covered. Care, treatment or Supplies for which a charge was Incurred before a person was Covered under this Plan.

(2) Excluded. Charges excluded or limited by the Plan design as stated in this document. Examples include, but are not limited to specialized lens designs or coatings, two pairs of eyeglasses in lieu of bifocal, and contact lenses and eyeglasses in the two Calendar Year period.

(3) Medical Treatment. Any charges that are Covered under the Plan's Medical Benefits for treatment of eye disease or Injury.

(4) Non-Licensed Personnel. Services not rendered by personnel qualified and licensed to render Services.

(5) No prescription. Charges for lenses ordered without a prescription.

HOW TO SUBMIT A CLAIM

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization.

PRESCRIPTION DRUG BENEFIT CLAIMS

If this Plan is the primary payer, the Claims Administrator is CVS/Caremark. Refer to the section entitled "Prescription Drug Benefits" shown previously in this document for details in obtaining In-Network and Out-of-Network Pharmacy and Mail Order Pharmacy benefits. If this Plan is secondary payer, you must submit the claims to POMCO to be processed under the Medical Benefits and Coordination of Benefit provision of the Plan. Refer to the section entitled "Other Claim Submissions" shown below for instructions on how to submit the claims to POMCO.

VISION CARE BENEFIT CLAIMS-Provider Choice Option only

The Claims Administrator for Vision Care Benefits is Davis Vision. Refer to the section entitled "Vision Care Benefits" shown previously in this document for details in obtaining In-Network and Out-of-Network Vision Care Benefits.

MEDICAL BENEFIT CLAIMS

For Medical Benefits, when the claim is processed, POMCO will send you an Explanation of Benefits Statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accurately.

For Medical Benefits, if Medicare or another health plan is considered the primary plan, claims should first be submitted to those plans and then to POMCO with copies of the itemized bill and the other carrier's explanation of benefits or denial. Claims for Services and Supplies needed for Illness or Injury resulting from automobile or No-Fault auto accidents or incidents, or for which benefits could be payable by a third party plan not owned by you or your Dependent, should be submittted first to the appropriate insurance company, then to this Plan for consideration. The No-Fault or third party plan is always primary for expenses resulting from these situations. Claims for Services and Supplies needed for expenses resulting from an occupational Illness or Injury follow the State and Federal workers' compensation, employers liability or occupational disease law as set forth in Article 11 NYCRR § 52.16 (c) (8). Be sure to give the Provider full details on other coverages to avoid overpayment of Plan benefits.

(1) In-Network Claims (Network Providers). When you use an In-Network Provider for Covered Services, you are not required to submit claims. The In-Network Providers bill the Claims Administrator directly for benefits. To obtain benefits, you and your Covered Dependents need only present your Plan identification card to confirm Plan eligibility and complete any information requested by the Provider. Be sure you give the In-Network Provider full history of any Accidental Injuries. The In-Network Provider may request that you pay the Plan Deductible and Percentage Coinsurance and any applicable Copayments at the time Services are given. If not, the Provider will bill you for the balance of the Network allowance not paid by the Plan. The payment of the balance and any non-Covered Services are your responsibility.

(2) Hospital/facility Inpatient or Hospital Outpatient Claims. Usually, the Hospital or other Inpatient facility will mail claims directly to the Claims Administrator. If you are billed directly, follow the instructionss for "Other Claims Submissions" shown later in this section. If you or your Covered Dependents are covered by more than one Plan, the Hospital/facility will usually bill the plans according to the Coordination of Benefits order of benefit determination. Usually the Hospital or other Inpatient

facility will provide payment information for Medicare and/or other health plan benefits when they submit your claims to POMCO. If not, POMCO may contact you with a written request for copies of the other Plans' explanation of benefits or denial. Be sure to give the Hospital or other facility full information on all your health plans to facilitate proper billing.

(3) Other Claims Submissions. When a Covered Person has a claim to submit for payment that person must:

(a) Obtain a claim form from the Participating School healthcare clerk or from POMCO.

(b) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(c) Have the Provider complete the Provider's portion of the form.

(d) For Plan reimbursements, attach bills for Services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, Tax ID and/or National Provider Identifier and telephone number of the Provider of care
- Diagnosis
- Type of Services rendered, with diagnosis and/or procedure codes
- Date of Services
- Charges

(e) Attach Medicare or other plan explanation of benefits or denial if applicable.

(f) Send the above to the Claims Administrator at this address:

Medical Benefits
POMCO
PO Box 6329
Syracuse, New York 13217-6329
1-888-201-5150

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator as Services are Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Notice and/or proof of claims must be submitted by March 31 of the Calendar Year following the Calendar Year in which the Covered expenses were Incurred. Claims filed later than that date may be declined or reduced unless:

(1) a claim submission to this Plan is delayed due to initial submissions to Medicare or another plan that is primary, then claims must be submitted to this Plan within 90 days after the date Medicare or the other plan processed their claims.

(2) this claim deadline period will not apply when the person is not legally capable of submitting the claim.

Failure to submit notice and/or proof of claims within the maximum time limits will result in denial of Plan benefits, even if expenses are otherwise Covered under the Plan, unless it is shown that it was not reasonably possible to furnish such proof within the time limit. Then proof must be submitted when reasonably possible.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

If the Plan cancels, proof must be submitted within 90 days after the Plan cancellation date.

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, nor shall any such action be brought at all unless commenced within three years from the date the Covered Service or Supply was Incurred.

CLAIMS APPEAL PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. The following appeal procedures apply:

(1) Denial due to Medical Necessity or Experimental and or Investigational. If the denial relates, in whole or in part, to a Medical Necessity or Experimental or Investigational adverse determination the following appeal procedure will apply.

Internal and expedited appeals for denial based on Medical Necessity or Investigational procedures should be sent to:

POMCO Appeals Unit
P. O. Box 6329
Syracuse, NY 13217-6329
Phone Toll-free 1-888-201-5150

(a) Utilization Review.

1. Prospective Reviews. If POMCO have all the information necessary to make a determination regarding a prospective; pre-service review, POMCO will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three business days of receipt of the request. If POMCO needs additional information, POMCO will request it within three business days. You or your Provider will then have 45 calendar days to submit the information. POMCO will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to prospective; pre-service urgent claims, if POMCO has all the information

necessary to make a determination, POMCO will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within 72 hours of receipt of the request. If POMCO needs additional information, POMCO will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. POMCO will make a determination and provide notice to you and your Provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

2. **Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If POMCO needs additional information, POMCO will request it within one business day. You or your Provider will then have 45 calendar days to submit the information. POMCO will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

   For concurrent reviews that involve urgent matters, POMCO will make a determination and provide notice to you (or your designee) and your Provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for [prospective; pre-service] urgent claims.

   If POMCO has approved a course of treatment, POMCO will not reduce or terminate the approved services unless POMCO has given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

3. **Retrospective Reviews**. If POMCO has all information necessary to make a determination regarding a retrospective claim, POMCO will make a determination and provide notice to you (or your designee) and your Provider within 30 calendar days of receipt of the claim. If POMCO needs additional information, POMCO will request it within 30 calendar days. You or your Provider will then have 45 calendar days to submit the information. POMCO will make a determination and provide notice to you and your Provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

4. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary or is Experimental/Investigational) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. POMCO will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

Your Right to an Immediate External Appeal. If POMCO fails to adhere to the utilization review requirements described in your Plan, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in your Plan.

Home Health Care Services. If POMCO receives a request for coverage of home health care services following an inpatient hospital admission, POMCO will notify you (or your designee) and your Provider of their decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information unless it is a prospective; pre-service urgent claim for which the prospective; pre-service urgent claim time frames are applicable.

When POMCO receives a request for home health care services and all necessary information prior to

your discharge from an inpatient hospital admission, POMCO will not deny coverage for home health care services, either on the basis of Medical Necessity or for failure to obtain prior authorization, while our decision on the request is pending.

You or your designee have up to 60 calendar days after you receive notice of the adverse determination to file an appeal.

POMCO will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee and, where appropriate, your health care provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

POMCO will decide internal appeals related to retrospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee and, where appropriate, your health care provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, home health care services following an inpatient hospital admission, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours of receipt of the appeal request or two business days of receipt of the necessary information. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your internal appeal within 30 calendar days of receipt of the necessary information for a standard appeal or two business days of receipt of the necessary information for an expedited appeal shall be deemed a reversal of the initial adverse determination.

(2) Standard Claim Appeals Procedure. If the benefit denial does not relate, in whole or in part, to a Medically Necessity or Investigational adverse determination, the following appeal procedure applies:

(a) Level I–First Appeal. Your appeal, in writing, must be mailed to the Claims Administrator within 60 days from the date of the claim denial notice. The appeal letter should properly identify the Covered Person, state why the claim should not be denied and include all supporting documents, information or comments concerning the claim.

The Plan reserves the right to maintain denial of benefits without further review for any appeals received more than 60 days after the initial notice of claim denial. Generally, you will receive written results of an appeal review within 60 days after the Claims Administrator received the appeal. In an unusually complex appeal, the review may necessarily be extended beyond 60 days, in which case you will be so advised. Your written appeal should be mailed to the Claims Administrator.

POMCO Appeals Unit
PO Box 6329
Syracuse, NY 13217-6329

If the outcome of a Level I-First Appeal results in an adverse claim determination, another review may be requested under Level II-Subsequent Appeal review shown below.

(b) Level II-Subsequent Appeal. If you are dissatisfied with the outcome of any Level I-First Appeal determination by the Claims Administrator, you may request a Level II-Subsequent Appeal.

If you receive a final adverse determination on the basis that Services are not Medically Necessary

or are Investigational, you may request a Level II- Subsequent Appeal. An appeal under this Level II- Subsequent Appeal could take londer than the 45 day timeframe for requesting External Appeals after a final adverse determination.

To submit a subsequent appeal, an appeal letter including all supporting documents, information and comments concerning the claim should be directed to the Chairperson of the Appeals Review Committee of the Plan Administrator within 30 days after the date you received the results from the first appeal. The Appeals Review Committee will notify you of their decision by mail. Your subsequent appeal should be sent to:

Chairperson, Appeals Review Committee
c/o The Plan Manager's Office
Jefferson-Lewis et.al. Schools
PO Box 456
Clayton, NY 13624

The Appeals Review Committee shall not consult or reveal any circumstances of the appeal to anyone other than the legal and healthcare professionals as may be necessary to obtain information or advise pertinent to the appeal.

Notice of Determination of Internal Appeal. The notice of determination of your internal appeal will provide the reasons for the determination, whether or not it is an adverse determination; and where adverse determination is upheld on appeal, the notice will include the clinical rationale for such determination. If the adverse determination is upheld on appeal, the notice will also explain your rights to an external appeal, together with a description of the external appeal process and the timeframes for initiating an external appeal. If you are dissatisfied with the final adverse determination, you may request an external appeal. You may also request a Level II-Subsequent Appeal under standard claim appeal procedures. **Note:** An appeal under the Level II-Subsequent Appeal could take longer than the 45 day time frame for requesting an external review after a final adverse determination. The 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determinzation of the first level appeal, regardless of whether a Level II appeal is requested. By choosing a request for a Level II-Subsequent Appeal, the time frame for requesting an external appeal could expire.

If you are dissatisfied with the Level I and/or Level II appeal determination or at any other time you are dissatisfied, you may call or write the New York State Department of Insurance at the address below:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
1-800-342-3736

(3) External Appeals Procedures. This provision shall be in accordance with the applicable New York State Insurance Law, as amended. To be eligible for external appeal, the final adverse determination must be based on a determination that the service is not Medically Necessary, or that the service is Investigational or Experimental. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your Coverage.

(a) Your right to an external appeal. Under certain circumstances, you have a right to request an external appeal of a denial of Coverage. Specifically, if the Plan denied coverage on the basis that the service is not Medically Necessary, or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), you or your representitive may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

(b) Your right to appeal a determination that a services in not Medically Necessary. If the Plan has denied coverage on the basis that the service is not Medicaly necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

1. The Service must otherwise be a Covered Service under this Plan; and

2. You must have received a final adverse determination through the first level of the Plan's internal appeal process, and the Plan must have upheld the denial or you and the Plan must agree to waive any internal appeal.

(c) Your right to appeal a determination that a service is Experimental or Investigational. If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following two (2) criteria:

1. The Service must otherwise be a Covered Service under this Plan; and

2. You must have received a final adverse determination through the first level of the Plan's internal appeal process, and the Plan must have upheld the denial or you and the Plan must agree to waive any internal appeal.

In addition, your attending Physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In case of a child under the age of eighteen, a " disabling condition or disease" is a medically determinable physical or mental impairment of comparable severity.

Your attending Physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or on for which there does not exist a more beneficial standard service or procedure Covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one of the following:

1. A Service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation-your attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affect fewer than 200,000 U.S. residents per year.

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

(d) The external appeal process. If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an Experimental or Investigational treatment you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application

with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver or an internal appeal.

You may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your Physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of the decision.

If the external appeal agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

(e) Your responsibilities. It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request; however, the Insurance Department may contact you a request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

COVERED SERVICES/EXLUSIONS

In general, the Plan does not cover Experimental or Investigational treatments. However, the Plan shall cover an Experimental or Investigational treatment approved by an external appeal agent in accordance the external appeal subsection of the Plan shown above. If the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trail, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is Covered by this Plan and another plan or plans, the plans will coordinate benefits when a claim is received. A coordination of benefits provision is one that is intended to avoid claim payment delays and duplication of benefits when a person is covered by two or more plans providing the same Services.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. **Exception:** See also "Medicare Integration" described in the next section.

When this Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses.

Benefit Plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group insurance and group or group remittance subscriber contracts.

(2) Uninsured arrangements of group coverage.

(3) Group coverage through HMO's and other prepayment, group practice and individual practice plans.

(4) Blanket contracts, other than blanket school accident coverage or similar coverage where the organization pays the premium.

(5) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(6) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(7) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law. See "Automobile limitations" shown later in this section for additional clarification of benefit integration.

Allowable Charge. For a charge to be allowable, it must be a Usual, Reasonable, and Customary Charge and at least part of it must be Covered under this Plan.

When an HMO (Health Maintenance Organization) or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the covered person used the Services of an HMO or network provider.

The amount benefits are reduced by the primary plan because a covered person does not comply with the primary plan's provisions, will be excluded under the COB provision. Examples of these provisions include, but are not limited to, mandatory requirements of a benefit management program, second surgical opinions, medical procedure review, preadmission review of precertification of Inpatient admissions and pre-approval requirements for certain treatment.

In the case of service type plans where Services are provided as benefits, the reasonable cash value of each Service will be the allowable charge.

This Plan will coordinate benefits with a plan which is excess or always secondary or which uses order of benefit determination rules which are inconsistent with those rules contained in this section on the following basis:

(1) If this Plan the primary plan, it shall pay or provide its benefits on a primary basis;

(2) If this Plan is the secondary plan and the primary plan claims it is "excess only" or "always secondary", we will request information from the primary plan so that we can process your claim.

(3) If the non-complying primary plan does not provide the information needed within 30 days, this Plan will assume its benefits are the same as ours and shall pay its benefits accordingly. In such a situation, such payment shall be the limit of this Plan's liability; unless

(4) The information is sent by the primary noncomplying plan after the 30 days, this Plan will adjust any payments it made based on assumption of benefits, to reflect the actual payments of the noncomplying primary plan. This Plan will never pay more than its normal liability had it been the primary plan.

For Medicare integration, see the next section shown below.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, with reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan payment order. The order of benefit payments is determined using the first of the following rules which applies.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year (month and day only; not year) are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(iii) If the other plan has not adopted the "birthday rule" as described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(c) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of that plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

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

(e) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B or C, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period and includes Allowed Charges Incurred during that period. However, it does not include any Allowed Charges Incurred during any part of the Calendar Year during which a person has had no Coverage under this Plan, or any part of the year before the date this COB provision takes effect.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

MEDICARE

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

(1) Medicare Payment Integration.

The Plan determines the allowable fee first, then pays the difference between the allowable fee and Medicare's payment up to the lesser of the balance of the bill or the Plan's normal benefit.

(2) Not enrolled in Medicare. This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare or incurs Services in a Veterans Administration Hospital/federal facility.

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. 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, Reasonable and Customary Charges for Covered Services or Supplies without regard to Medicare deductibles and other coinsurance limits.

For Services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A Services will be estimated according to Medicare payment rules. Part B Services will be estimated, based on 80% of Usual, Reasonable and Customary Charges for Covered Services or Supplies without regard to Medicare deductibles and other coinsurance limits.

(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. Part A Services will be estimated according to Medicare payment rules. Part B Services or similar Services under Part C will be estimated, based on 80% of Usual, Reasonable, and Customary 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 Part C (Medicare Advantage). This integration will not apply when Medicare and a Medicare-sponsored HMO deny Coverage due to its enrolled beneficiary's failure to abide by the HMO or participating provider program requirements. This Plan will not cover the expenses for those Services or Supplies and Plan benefits will not be paid.

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, Reasonable and Customary Charges for Out-of-Network Providers, the Network allowance for Network Providers 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, Reasonable and Customary Charges or the Participating Provider Network allowance, if applicable 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.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

New York General Obligations Law (GOL) § 5-335 provides that a right of subrogation does not apply when a settlement is reached between a plaintiff and defendant except where there is a statutory right of reimbursement. It further provides that by entering into such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any non-statutory right of any benefit provider that paid medical expenses; nor does a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider. In addition, GOL § 5-335 sets forth the presumption that a settlement between a plaintiff and defendant does not include compensation for the cost of health care services to the extent those expenses are paid or reimbursed by a benefit provider.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Same-gender Spouses are allowed the same rights as an opposite gender Spouse for Covered Services under this Plan. However, there is no provision for same-gender Spouses under the terms of the federal COBRA regulations. COBRA continuation of benefits is not available for same-gender Spouses.

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and similar New York State Law, certain Employees and their families Covered under the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health Coverage (called "COBRA continuation Coverage") where Coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation Coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is the Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan, PO Box 456, Clayton, New York 13624, 1-888-865-2722. COBRA continuation Coverage for the Plan is administered by POMCO, 2425 James St., Syracuse, New York 13206, 1-888-201-5150. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation Coverage? COBRA continuation Coverage is the temporary extension of group health Plan Coverage that must be offered to certain Plan Participants and their eligible Family Members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation Coverage is triggered by the occurrence of a life event that results in the loss of Coverage under the terms of the Plan (the "Qualifying Event"). The Coverage must be identical to the Plan Coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the Coverage has been changed, the Coverage must be identical to the Coverage provided to similarly situated active Employees/Retiree who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is Covered under a Plan by virtue of being on that day either a Covered Employee/Retiree, the Spouse of a Covered Employee/Retiree, or a Dependent child of a Covered Employee/Retiree. If, however, an individual is denied or not offered Coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan Coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a Covered Employee/Retiree during a period of COBRA continuation Coverage, and any individual who is Covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered Coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan Coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A Covered Employee who retired on or before the date of substantial elimination of Plan Coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a Covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "Covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided Coverage under the Plan due to his or her performance of Services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee/Retiree during a period of COBRA continuation Coverage) must be offered the opportunity to make an independent election to receive COBRA continuation Coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose Coverage (i.e., cease to be Covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation Coverage:

(1) The death of a Covered Employee/Retiree.
(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.
(3) The divorce of a Covered Employee/Retiree from the Employee's/Retiree’s Spouse.
(4) A Covered Employee's/Retiree’s enrollment in any part of the Medicare program.
(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan). However, Dependents who are Covered under the “Young Adult Option” and loses eligibility are not eligible for COBRA continuation coverage.
(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Employee retired at any time.

If the Qualifying Event causes the Covered Employee/Retiree, or the Covered Spouse or a Dependent child of the Covered Employee/Retiree, to cease to be Covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of Coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such Coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee/Retiree, or the Spouse, or a Dependent child of the Covered Employee/Retiree, for Coverage under the Plan that results from the occurrence of one of the events listed above is a loss of Coverage .

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation Coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum Coverage period is measured from this date (unless Coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum Coverage date is measured from the date when the Coverage is lost.) Note that the Covered Employee and Family Members will be entitled to COBRA continuation Coverage even if they failed to pay the Employee portion of premiums for Coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation Coverage? You

should take into account that a failure to continue your group health Coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation Coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation Coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan Coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation Coverage if you get COBRA continuation Coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation Coverage? The Plan has conditioned the availability of COBRA continuation Coverage upon the timely election of such Coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation Coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose Coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose Coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation Coverage.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation Coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date Coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,
(2) death of the Employee/Retiree,
(3) commencement of a proceeding in bankruptcy with respect to the Employer, or
(4) enrollment of the Employee/Retiree in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce of the Employee/Retiree and Spouse or a Dependent child's losing eligibility for Coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses Coverage will not be offered the option to elect continuation Coverage. You must send this notice to the Plan Sponsor or designee.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the healthcare clerk at your Participating School, at the appropriate address:

Alexandria Central 34 Bolton Ave. Alexandria, NY 13607	Beaver River Central PO Box 179 Art 2 Rd. Beaver Falls, NY 13305	Belleville – Henderson Central PO Box 158 8372 County Route 75 Belleville, NY 13611	Carthage Central School District Office 25059 County Route 197 Carthage, NY 13619
Copenhagen Central PO Box 30 Mechanic Street Copenhagen, NY 13626	General Brown Central 17643 Cemetery Rd. Dexter, NY 13634	General Brown Central 17643 Cemetery Rd. Dexter, NY 13634	Jefferson Community College Outer Coffeen Street Watertown, NY 13601
Jefferson-Lewis BOCES 20104 NYS Route 3 Watertown, NY 13601	Lafargeville Central School 20414 Sunrise Avenue Lafargeville, NY 13656	Lowville Central 7668 State Street Lowville, NY 13367	Lyme Central PO Box 219 11868 Academy Street

			Chaumont, NY 13622
Sackets Harbor Central PO Box 290 215 S. Broad Street Sackets Harbor, NY 13685	South Lewis Central 5 PO Box A East Road Turin, NY 13473	Thousand Island Central 600 High Street Clayton, NY 13624	Watertown City Schools 376 Butterfield Ave. Watertown, NY 13601

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage ,
- the name and address of the Employee/Retiree Covered under the Plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce, your notice must include a copy of the divorce decree.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation Coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation Coverage. Covered Employees/Retirees may elect COBRA continuation Coverage for their Spouses, and parents may elect COBRA continuation Coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation Coverage, COBRA continuation Coverage will begin on the date that Plan Coverage would otherwise have been lost (if under your plan the COBRA period begins on the date of the Qualifying Event, even though Coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your Spouse or Dependent children do not elect continuation Coverage within the 60-day election period described above, the right to elect continuation Coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation Coverage. However, if a waiver is later revoked, Coverage need not be provided retroactively (that is, from the date of the loss of Coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When may a Qualified Beneficiary's COBRA continuation Coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation Coverage. Except for an interruption of Coverage in connection with a waiver, COBRA continuation Coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum Coverage period.
(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
(4) The date, after the date of the election, that the Qualified Beneficiary first becomes Covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

The Plan can terminate for cause the Coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the Coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving Coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make Coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum Coverage periods for COBRA continuation Coverage? The maximum Coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum Coverage period ends 36 months after the Qualifying Event.
(2) In the case of a bankruptcy Qualifying Event, the maximum Coverage period for a Qualified Beneficiary who is the Covered Retiree ends on the date of the Retiree's death. The maximum Coverage period for a Qualified Beneficiary who is the Covered Spouse, surviving Spouse or Dependent child of the Retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the Retiree.
(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation Coverage, the maximum Coverage period is the maximum Coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation Coverage during which the child was born or placed for adoption.
(4) In the case of any other Qualifying Event than that described above, the maximum Coverage period ends 36 months after the Qualifying Event.

Does the Plan require payment for COBRA continuation Coverage? For any period of COBRA continuation Coverage under the Plan, qualified beneficiaries who elect COBRA continuation Coverage must pay for COBRA continuation Coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation Coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation Coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation Coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation Coverage? Timely Payment means a payment made no later than 30 days after the first day of the Coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their Coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for Coverage of similarly situated non-COBRA beneficiaries for the period.

Not withstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation Coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation Coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of Coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health Plan at the end of the maximum Coverage period for COBRA continuation Coverage? If a Qualified Beneficiary's COBRA continuation Coverage under a group health Plan ends as a result of the expiration of the applicable maximum Coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally

available to similarly situated non-COBRA beneficiaries under the plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation Coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of Family Members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Jefferson-Lewis et. al. Schools Employees' Healthcare Plan is the benefit Plan of the Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan, the Plan Administrator, also called the Plan Sponsor.

An individual may be appointed by Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan to be Plan Sponsor and serve at the convenience of the Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan. If the Plan Sponsor resigns, dies or is otherwise removed from the position, the Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan shall appoint a new Plan Sponsor as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired Services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee/Retiree and Dependent Coverage: Funding is derived from the funds of the Participating Employer Schools and contributions made by the Covered Employees/Retirees.

The level of any Employee/Retiree contributions will be set by the Plan Administrator. These Employee/Retiree contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate Coverage otherwise validly in force or continue Coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

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 Dependents 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. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim; 30 calendar days advance notice will be provided. 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.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

Pursuant to New York State Insurance Department approval, the Plan Administrator may reduce, revise, or cancel any or all of the benefits, limitations, provisions, inclusions or exclusions of the Plan. Any changes so made shall be binding on all persons Covered by the Plan. If the Plan cancels, Coverage will end for all persons enrolled under the Plan. All participants in the Plan will be notified in writing, at least 90 days before such cancellation.

The contents of the Plan's SPD which describes the Plan provisions, are subject to approval by the New York State Department of Insurance. The benefits, terms and conditions could change without notice pending its review.

HIPAA COMPLIANCE

The federal Health Insurance and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the portability, confidentiality, integrity, security and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Employee/Retiree Covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Covered Person. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's Privacy Officer at the Participating School.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Participating Schools and contributions made by Covered Employees and Retired Employees. The Plan is not insured.

PLAN NAME: Jefferson-Lewis et. al. Schools Employees' Healthcare Plan

PLAN OPTIONS: Traditional Option, and Provider Choice Option

PLAN EFFECTIVE DATE: July 1, 1979

PLAN RESTATEMENT DATE: July 1, 2011

PLAN YEAR ENDS: June 30th

PLAN ADMINISTRATOR: Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan

PLAN SPONSOR: Board of Trustees for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan

PLAN MANAGER: Edgar J. Higgins, Jr., CPCU, Plan Manager/Controller for the Jefferson-Lewis et. al. Schools Employees' Healthcare Plan

CLAIMS ADMINISTRATOR:

Medical Expense Benefits
POMCO
P O Box 6329
Syracuse, New York 13217-6329
1-888-201-5150

Prescription Drug Benefits
CVS/Caremark
620 Epsilon Drive
Pittsburgh, PA 15238
1-800-581-5300

CVS/Caremark Mail Order
PO Box 419096
Kansas City, MO 64179-0844
1-800-222-3383

Vision Care Benefits (Provider Choice Option Only)
Davis Vision
PO Box 2270
Schenectady, NY 12301
1-800-999-5431

BY THIS AGREEMENT, Jefferson-Lewis et. al. Schools Employees' Healthcare Plan is hereby adopted as shown.

IN WITNESS WHEREOF, the Plan Administrator, for Jefferson-Lewis et. al. Schools has caused this restatement of Master Plan Document and Summary Plan Description for the self -funded Jefferson-Lewis et. al. Schools Employees' Healthcare Plan to be executed in its name and behalf as of the 1st day of July 2011.

By ___________________________________

Title__________________________________