

**BEDFORD CENTRAL SCHOOL DISTRICT**

**HEALTH BENEFIT PLAN**

**PLAN DOCUMENT**

**AND**

**SUMMARY PLAN DESCRIPTION**

Effective Date: January 1, 2019

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# SUMMARY PLAN DESCRIPTION

**Name of Plan:**

Bedford Central School District Health Benefit Plan

**Name, Address and Phone Number of Employer/Plan Sponsor:**

Bedford Central School District  
632 South Bedford Road  
Bedford, New York 10506  
(914) 241-6000

**Employer Identification Number:**

13-6012148

**Group Number:**

BE

**Type of Plan:**

Welfare Benefit Plan: medical, dental and prescription drug benefits

**Type of Administration:**

Contract administration: The processing of claims for benefits under the terms of the *Plan* is provided through one or more companies contracted by the *employer* and shall hereinafter be referred to as the *claims processor*.

**Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:**

Bedford Central School District  
632 South Bedford Road  
Bedford, New York 10506

Legal process may be served upon the *plan administrator*.

**Name, Title, Address and Principal Place of Business for Plan Trustees:**

Bedford Central School District  
632 South Bedford Road  
Bedford, New York 10506

**Union Plans:**

The *Plan* is established in accordance with a collective bargaining agreement. *Employees/retirees* have a right to obtain a copy of the collective bargaining agreement. A written request for such copy should be submitted to the *plan administrator*. The collective bargaining agreement is available for examination in the *plan administrator's* office.

**Eligibility Requirements:**

For detailed information regarding a person's eligibility to participate in the **Plan**, refer to the following section:  
*Eligibility, Enrollment and Effective Date*

For detailed information regarding a person being ineligible for benefits through reaching **Essential Health Benefit/non-Essential Health Benefit maximum benefit** levels, termination of coverage or **Plan** exclusions, refer to the following sections:

*Schedule of Benefits*  
*Termination of Coverage*  
*Plan Exclusions*

**Source of Plan Contributions:**

Contributions for **Plan** expenses are obtained from the **employer** and from covered **employees/retirees**. The **employer** evaluates the costs of the **Plan** based on projected **Plan** expenses and determines the amount to be contributed by the **employer** and the amount to be contributed by the covered **employees/retirees**. Contributions by the covered **employees** are deducted from their pay on a pre-tax basis as authorized by the **employee** on the enrollment form (whether paper or electronic) or other applicable forms.

**Funding Method:**

The **employer** pays **Plan** benefits and administration expenses directly from general assets. Contributions received from **covered persons** are used to cover **Plan** costs and are expended immediately.

**Ending Date of Plan Year:**

December 31

**Standards Relating to Benefits for Mothers and Newborns:**

If the *Schedule of Benefits* shows that you have coverage for **pregnancy** and newborn care, this **Plan** 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, this **Plan** may not, under Federal law, require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.

**Preferred Provider Networks**

This **Plan** may contain a **Preferred Provider Organization** (PPO) network and pre-certification requirements. Refer to the **Plan** for detailed information concerning pre-certification and **Preferred Provider** requirements. For a listing of **Preferred Providers**, contact the PPO network listed on your identification card.

**Procedures for Filing Claims:**

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled *Claim Filing Procedure*.

The designated **claims processor**:

CoreSource, Inc.  
P.O. Box 2920  
Clinton, IA 52733-2920

# SCHEDULE OF BENEFITS

**Benefit Period: January 1 – December 31**

**NOTE:** For eligible post 65 retirees, benefits will be considered at the *preferred provider* level of benefits.

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
<b>Deductible</b> ( <i>per benefit period</i> )		
Individual	\$0	\$400
Family	\$0	\$1,375
<p>Generally, you must pay all of the costs from providers up to the deductible amount before <b>Plan</b> begins to pay. If you have other family members in this <b>Plan</b>, they have to meet their own individual deductible until the overall family deductible amount has been met.</p>		
<p><b>Preferred Out-of-Pocket Expense Limit</b> (includes deductible, <i>coinsurance</i>, <i>copays</i> and prescription cost-share)  <b>Nonpreferred Out-of-Pocket Expense Limit</b> (includes deductible and <i>coinsurance</i>)</p>		
<b>Out-of-Pocket Expense Limit does share between Preferred and Nonpreferred</b>		
<p>The out-of-pocket expense limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>		
<b>Out-of-Pocket Expense Limit</b> ( <i>per benefit period</i> )		
<b>NOTE:</b> The nonpreferred (medical) out-of-pocket limit does not apply toward the hospital nonpreferred out-of-pocket limit.		
Individual	\$4,600	Not applicable
Family	\$9,200	\$3,025
<p>The <b>Plan</b> will pay the designated percentage of <b>covered expenses</b> until the out-of-pocket expense limits are reached, at which time the Plan will pay 100% of the remainder of <b>covered expenses</b> for the rest of the benefit period unless stated otherwise.</p> <p>The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:</p> <ul style="list-style-type: none"> <li>• expenses not covered by the <b>Plan</b></li> <li>• expenses in excess of amounts covered by the <b>Plan</b></li> <li>• expenses in excess of <b>customary and reasonable amount</b></li> </ul>		
HOSPITAL OUT-OF-POCKET EXPENSE LIMIT	PREFERRED PROVIDER	NONPREFERRED PROVIDER
<b>Out-of-Pocket Expense Limit</b> (per calendar year)		
<b>NOTE:</b> The nonpreferred hospital out-of-pocket limit does not apply toward the (medical) nonpreferred out-of-pocket limit.		
Individual	Not applicable	Not applicable
Family	Not applicable	\$1,650
	PREFERRED PROVIDER	NONPREFERRED PROVIDER

<b>Standard coinsurance paid by the Plan</b>	100%	80% after deductible
<b>Services within the network where no Preferred Provider is available</b>		80% after deductible
<b>Services at a Preferred Provider facility rendered by a Nonpreferred provider when the member has no choice of provider.</b> <i>For example, ancillary services such as radiology, pathology, laboratory and anesthesia.</i>		80% after deductible

<b>NETWORK COPAY LIMIT</b>
\$20 per provider per type of service. <b>Copay Limit: \$60</b> per <i>covered person</i> per event (all services by the same provider on the same day). Outpatient hospital network copays do <u>not</u> apply to the network copay limit.
<b>PRE-CERTIFICATION REQUIREMENTS</b>
Inpatient Admissions (hospital, rehabilitation, skilled nursing, transplant, behavioral medicine such as psychiatric and substance abuse)
Partial Confinements
Home Health Care (including infusions and hospice)
Dilatation and Curettage (unrelated to pregnancy)
Gastric Stapling/Bariatric Surgery (weight reduction surgical procedures)
Hernia Repair (laparoscopic)
MRA (magnetic resonance angiography)
MRI (magnetic resonance imaging)
Varicose Vein Surgery
Failure to comply will result in a \$250 penalty. <i>Covered persons</i> shall contact the <i>Health Care Management Organization</i> by calling the number shown on their ID card.

<b>MEDICAL BENEFITS</b>	<b>PREFERRED PROVIDER</b> % of <i>negotiated rate</i> , if applicable	<b>NONPREFERRED PROVIDER</b> % of the <i>fair allowable amount</i>
<b>Acupuncture</b>	\$20 copay, then 100% deductible waived	Not covered
	10 visits in a calendar year	Not applicable
<b>Allergy Services</b>		
Allergy Injections and Serum	\$20 copay, then 100% deductible waived	80% after deductible
Allergy Testing	\$20 copay, then 100% deductible waived	80% after deductible
<b>Ambulance (Land/Air)</b>		
Emergency	100% deductible waived	100%
Non-Emergency	80% after nonpreferred provider deductible	80% after deductible
<b>Ambulatory Surgical Facility/Freestanding Facility</b>	80% after nonpreferred provider deductible	80% after deductible
<b>Anesthesia</b>	100% deductible waived	80% after deductible

<b>Applied Behavior Therapy (ABA)</b>	Not covered	Not covered
<b>Bereavement Counseling</b>	100% deductible waived	100% deductible waived
<b>Biofeedback Training</b>	\$20 copay, then 100% deductible waived	80% after deductible
<b>Birthing Center</b>	100% deductible waived	80% deductible waived, subject to hospital out-of-pocket maximum
<b>Blood</b> ( <i>blood storage and transfusions</i> )	\$20 copay, then 100% deductible waived	80% after deductible
<b>Cardiac Rehabilitation</b> Freestanding Facility/Physician Office Outpatient Hospital	\$20 copay, then 100% deductible waived 80% after nonpreferred provider deductible	80% after deductible 80% after deductible
Maximum: 3 times per week and up to a maximum 18 consecutive weeks		
<b>Chemotherapy</b> Freestanding Facility/Physician Office Outpatient Hospital	\$20 copay, then 100% deductible waived 80% after nonpreferred provider deductible	80% after deductible 80% after deductible
<b>Chiropractic Care</b> Office Visits Spinal Manipulation, Adjustments and X-Rays	\$20 copay, then 100% deductible waived 100% deductible waived	80% after deductible 80% after deductible
Maximum: \$750 per Covered Person per Calendar Year combined preferred provider and nonpreferred provider.		
<b>Clinic</b> Facility Physician	80% after nonpreferred provider deductible \$20 copay, then 100% deductible waived	80% after deductible 80% after deductible
<b>Clinical Trials</b> ( <i>excludes the actual clinical trial</i> )	100% deductible waived	Not covered
Plan only covers the routine costs in connection with an approved clinical trial for a qualified individual. NonPreferred providers are only available if a Preferred provider is not available.		
<b>Consultations - Inpatient</b>	100% deductible waived	80% after deductible
<b>Contact Lenses/Eyeglasses Following Intraocular/Cataract Surgery</b>	100% deductible waived	80% after deductible
<b>Dental Care, Limited</b>	Pay as service rendered	Pay as service rendered
<b>Diabetic Education</b>	\$20 copay, then 100% deductible waived	80% after deductible
<b>Diabetic Supplies/Equipment</b>	100% deductible waived	80% after deductible

<b>Dialysis Therapy or Treatment</b> Freestanding Facility/Physician Office Outpatient Hospital	\$20 copay, then 100% deductible waived 100% deductible waived	\$20 copay, then 100% deductible waived 80% deductible waived, subject to hospital out-of-pocket maximum
<b>Diagnostic Services – Major</b> <i>(such as MRI, MRA, CT Scan, PET Scan - pre-certification required for MRIs &amp; MRAs)</i> Independent/Freestanding Facility/Physician Office  Outpatient Hospital  Professional interpretation	\$20 copay, then 100% deductible waived  \$35 copay, then 100% deductible waived  \$20 copay, then 100% deductible waived	80% after deductible  80% deductible waived, subject to hospital out-of-pocket maximum 80% after deductible
<b>Diagnostic Services – Minor</b> <i>(such as x-ray, lab)</i> Independent/Freestanding Facility/Machine Testing/Physician Office Outpatient Hospital – Patient present  – Patient not present  Professional Interpretation	\$20 copay, then 100% deductible waived  \$35 copay, then 100% deductible waived  80% after nonpreferred provider deductible \$20 copay, then 100% deductible waived	80% after deductible  80% deductible waived, subject to hospital out-of-pocket maximum  80% after deductible 80% after deductible
<b>Durable Medical Equipment</b>	100% deductible waived	80% after deductible
<b>Emergency Services (for an emergency)</b> Facility Physician	100% \$20 copay, then 100% deductible waived	100% \$20 copay, then 100% deductible waived
<b>Emergency Services (not for an emergency)</b> Facility  Physician	80% after nonpreferred provider deductible \$20 copay, then 100% deductible waived	80% after deductible  80% after deductible
<b>Food Products</b> <i>(aminoacidopathies formula, enteral formulas, modified solid food products)</i>	Not covered	Not covered
<b>Hearing</b> Routine Exam Hearing Aids	Not covered Not covered	Not covered Not covered

<b>Home Health Care</b> <i>(pre-certification required)</i> Home Health Care Visits Home Health Care Supplies & Services IV Therapy	100% deductible waived 100% deductible waived 100% deductible waived	100% deductible waived 100% deductible waived 100% deductible waived
	Maximum: 365 days per Spell of Illness/Injury. 3 visits by a member of the Home Health Care team equals 1 benefit day. 4 hours of home health care equal 1 visit.	
<b>Hospice Care</b> Inpatient <i>(pre-certification required)</i> Outpatient	100% deductible waived 100% deductible waived	100% deductible waived 100% deductible waived
<b>Hospital – Inpatient</b> <i>(pre-certification required)</i> Facility  Physician  See section titled “Hospital/Ambulatory Surgical Facility” for further information	100% deductible waived  100% deductible waived	80% deductible waived, subject to hospital out-of-pocket maximum 100% deductible waived
	Maximum: 365 days per Spell of Illness/Injury. Once the 365 per Spell of Illness/Injury days is exhausted, any additional days will be paid at 80% after Deductible	
<b>Hospital - Outpatient Facility</b>	\$35 copay, then 100% deductible waived	80% deductible waived, subject to hospital out-of-pocket maximum
<b>Impotency Treatment</b>	Pay as service rendered	Pay as service rendered
<b>Infertility Services</b>	Pay as service rendered	Pay as service rendered
	AI, IUI and IVF are covered - see section titled “Infertility Services” for further information	
<b>Infusion Therapy</b> Freestanding Facility/Physician Office Outpatient Hospital	\$20 copay, then 100% deductible waived 80% after nonpreferred provider deductible	80% after deductible 80% after deductible
<b>Injectables</b> <i>(see Allergy Services for allergy shots/see Therapeutic Injections for therapeutic injections)</i>	\$20 copay, then 100% deductible waived	80% after deductible
<b>Massage Therapy</b>	Not covered	Not covered
<b>Mental and Nervous Disorders and Substance Abuse</b> Inpatient <i>(pre-certification required)</i> Outpatient/Office Visit  Outpatient Other Services	100% deductible waived	80% deductible waived, subject to hospital out-of-pocket maximum
	\$20 copay, then 100% deductible waived	80% after deductible
	100% after deductible	80% after deductible
<b>Nursing, Private Duty</b> Inpatient Outpatient	Not covered 100% deductible waived	Not covered 80% after deductible

<p><i>(following the 48 hour exclusion - Limited to \$30 per hour for an approved plan of care - charges more than \$30 per hour are not covered)</i></p>		
	<p>The charges for the first 48 hours of covered services in a calendar year are excluded. After the 48 hours of covered services, benefits for an approved plan of care are payable as shown below. Qualified Home Health Care services are covered under “Home Health Care” shown previously in this document.</p>	
<p>Visiting Nurse</p>	<p>100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Therapy Services</b> <i>(physical, speech, occupational )</i> Freestanding Facility/Physician Office Occupational &amp; Physical Therapy Outpatient Hospital <i>(therapy that starts within 6 months and is rendered within 365 days after related surgery or after discharge from related inpatient hospitalization)</i> Speech Therapy Outpatient Hospital</p>	<p>\$20 copay, then 100% deductible waived</p> <p>\$35 copay, then 100% deductible waived</p> <p>80% after nonpreferred provider deductible</p>	<p>80% after deductible</p> <p>80% deductible waived, subject to hospital out-of-pocket maximum</p> <p>80% after deductible</p>
<p><b>Office Visit &amp; Other Services</b> <i>(includes nurse practitioners and physician assistants)</i></p>	<p>\$20 copay, then 100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Orthotics</b></p>	<p>100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Podiatry Services</b></p>	<p>Pay as service rendered</p>	<p>Pay as service rendered</p>
<p><b>Pregnancy</b> Initial Pre-Natal Visit and Urinalysis Subsequent Pre-Natal Visits/Care and Breastfeeding Services and Supplies (as required by the <b><i>Affordable Care Act</i></b>) Post-Natal Care and Other Non-Routine/Non-Preventive Pregnancy Related Care.Delivery</p>	<p>100% deductible waived 100% deductible waived</p> <p>Pay as service rendered</p> <p>100% deductible waived</p>	<p>80% after deductible 80% after deductible</p> <p>80% after deductible</p> <p>80% after deductible</p>

<b>Newborn Care</b> Circumcision Hospital Physician	100% deductible waived 100% deductible waived 100% deductible waived	100% deductible waived 100% deductible waived 100% deductible waived
<p>Limited to allowable charges by a physician for routine pediatric care after birth while the newborn child is hospital confined. 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.</p>		

<p><b>Preventive Care</b> Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). Unless specifically listed below, for additional information visit: <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a></p>	100% deductible waived	Not covered
Bone Mineral Density Measurements and Tests	100% deductible waived	80% deductible waived
BRCA Genetic Counseling (related to genetic screening for breast and ovarian cancer)	100% deductible waived	80% after deductible
Colorectal Cancer Screening	100% deductible waived	80% deductible waived
Human Papillomavirus (HPV) DNA Testing	100% deductible waived	80% deductible waived
Mammography, Routine		
<ul style="list-style-type: none"> <li>● Mammography, recommended by a <i>physician</i> for <i>covered persons</i>, at any age, having a prior history of breast cancer, or who have a first degree relative with a prior history of breast cancer.</li> <li>● A single baseline mammography for <i>covered persons</i> 35-39 years of age.</li> <li>● A mammography every two years for <i>covered persons</i> who are 40-49 years of age, or more frequently upon recommendation of a <i>physician</i> with medical rationale;</li> <li>● An annual mammography for <i>covered persons</i> 50 years of age or older. Includes services rendered in a hospital outpatient setting, clinic or physician's office including interpretation. In no event, will the plan pay for more than one routine mammography screening in any one calendar year. <ul style="list-style-type: none"> <li>- Outpatient hospital</li> <li>- Other providers</li> </ul> </li> </ul>		
<ul style="list-style-type: none"> <li>- Outpatient hospital</li> </ul>	100% deductible waived	\$25 copay, then 100% deductible waived
<ul style="list-style-type: none"> <li>- Other providers</li> </ul>	100% deductible waived	80% after deductible
Prenatal Screening	100% deductible waived	80% after deductible
Well Adult Care (age 18 and older)	100% deductible waived	80% deductible waived

<p><b>Women's Preventive Care</b> As required by the Patient Protection and Affordable Care Act:</p> <p>Screening for gestational diabetes in a pregnant woman;</p> <p>Human papillomavirus DNA testing every three (3) years for women age thirty (30) and above;</p> <p>Annual counseling for sexually transmitted infections for a sexually active woman;</p> <p>Annual counseling and screening for human immune-deficiency virus for a sexually active woman;</p> <p>FDA approved contraceptive methods;</p> <p>Sterilization procedures, patient education and counseling for women with reproductive capacity;</p> <p>Breastfeeding support, supplies and counseling in conjunction with each birth, including the cost of purchasing or renting breastfeeding equipment; and</p> <p>Annual screening and counseling for interpersonal and domestic violence.</p>	<p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p> <p>100% deductible waived</p>	<p>80% deductible waived</p> <p>80% deductible waived</p> <p>80% deductible waived</p> <p>80% deductible waived</p> <p>Not covered</p> <p>80% after deductible waived</p> <p>Not covered</p> <p>80% deductible waived</p>
<p><b>Private Duty Nursing</b> Outpatient only - limited to \$30 per hour for an Approved Plan of Care. Charges more than \$30 per hour are not covered.</p>	<p>100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Prostate Examinations</b></p>	<p>100% deductible waived</p>	<p>Not covered</p>
<p><b>Prostheses</b></p>	<p>\$20 copay, then 100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Pulmonary Rehabilitation</b> Freestanding Facility/Physician Office Outpatient Hospital</p>	<p>\$20 copay, then 100% deductible waived 80% after nonpreferred provider deductible</p>	<p>80% after deductible 80% after deductible</p>
<p><b>PUVA</b> (psoralen &amp; ultraviolet radiation light therapy)</p>	<p>100% deductible waived</p>	<p>80% after deductible</p>
<p><b>Radiation Therapy</b> Freestanding Facility/Physician Office Outpatient Hospital</p>	<p>\$20 copay, then 100% deductible waived 100% deductible waived</p>	<p>80% after deductible 80% deductible waived, subject to hospital out-of-pocket maximum</p>
<p><b>Refractive Surgery</b></p>	<p>Not covered</p>	<p>Not covered</p>

<b>Respiratory Therapy</b> Freestanding Facility/Physician Office Outpatient Hospital	\$20 copay, then 100% deductible waived 80% after nonpreferred provider deductible	80% after deductible 80% after Deductible
<b>Second Surgical Opinion</b> Mandatory Voluntary	100% deductible waived \$20 copay, then 100% deductible waived	100% deductible waived 80% after deductible
<b>Skilled Nursing</b> <i>(pre-certification required)</i>	100% deductible waived	100% deductible waived
	Maximum: 150 Days per Spell of Illness/Injury. Once the 150 per Spell of Illness/Injury days is exhausted, the skilled nursing benefit days will count toward the 365 per Spell of Illness/Injury Hospital - Inpatient days.	
<b>Surgery</b> Surgeon, Assistant Surgeon, Anesthesiologist Inpatient Outpatient/Physician Office	100% deductible waived \$20 copay, then 100% deductible waived	80% after deductible 80% after deductible
<b>Therapeutic Injections</b>	100% deductible waived	80% after deductible
<b>Temporomandibular Joint Syndrome (TMJ) Treatment</b>	Not covered	Not covered
<b>Telemedicine Visit</b> <i>(from Teladoc)</i>	\$20 Copay	
<b>Transplants (Organ or Tissue)</b> <i>(pre-certification required)</i> Facility	Pay as service rendered	Pay as service rendered
Physician Travel/Meals Lodging	Pay as service rendered Not covered	Pay as service rendered Not covered
<b>Urgent Care</b> Facility/Physician  All Other Services	\$20 copay, then 100% deductible waived Pay as service rendered	80% after deductible Pay as service rendered
<b>Urgent Care - Retail Clinic</b>	\$20 copay, then 100% deductible waived	80% after deductible
<b>Vision - Routine Services</b>	Not covered	Not covered
<b>Voluntary or Elective Abortion</b>	Not covered	Not covered
<b>Voluntary or Elective Sterilization (Female)</b>	100% deductible waived	80% after deductible
<b>Voluntary or Elective Sterilization (Male)</b>	100% deductible waived	80% after deductible
<b>Weight Loss Services</b> Surgical Treatment <i>(pre-certification required)</i>	Pay as service rendered Pay as service rendered	Pay as service rendered Pay as service rendered

Non-Surgical Treatment and Programs	Maximum: Bariatric Surgery is limited to once per <i>covered person</i> in a lifetime.	
<b>Wigs after Cancer Therapy</b>	100% deductible waived	100% deductible waived
	Maximum: \$250 in a lifetime	
<b>All Other Covered Expenses</b>	100% deductible waived	80% after deductible

<b>PRESCRIPTION DRUG OUT-OF-POCKET EXPENSE LIMIT</b>	<b>PREFERRED PROVIDER</b>	<b>NONPREFERRED PROVIDER</b>
<b>Out-of-Pocket Expense Limit</b> (per calendar year)		
Individual	\$2,000	
Family	\$4,000	
<b>PRESCRIPTION DRUG BENEFITS</b>	<b>PREFERRED PROVIDER</b>	<b>NONPREFERRED PROVIDER</b>
If the <i>covered person</i> selects a brand drug when a generic equivalent is available, the <i>covered person</i> is responsible for the generic copay plus the cost difference between the generic and brand equivalent. If the physician indicates no substitutions, the <i>covered person</i> is only responsible for the brand copay.		
<b>Retail Pharmacy</b> (34-day supply or 100 unit doses, whichever is greater)		
Generic	\$10 copay	\$10 copay
Preferred Brand Name	\$30 copay	\$30 copay
Nonpreferred Brand Name	\$30 copay	\$30 copay
Specialty Drugs	Same as above	Same as above
Specified Drugs - Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol and Theo-Dur	\$15 copay	\$15 copay
<b>Mail Order Pharmacy</b> (90-day supply)		
Generic	\$13 copay	Not covered
Preferred Brand Name	\$35 copay	Not covered
Nonpreferred Brand Name	\$35 copay	Not covered
Specified Drugs - Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol and Theo-Dur	\$20 copay	Not covered

<b>DENTAL BENEFITS</b>	
Deductible ( <i>per benefit period</i> ) Individual Family	\$25 \$75
<b>Maximum Benefit</b> Class I, II, III Combined ( <i>per person per benefit period</i> ) Class IV - Orthodontic Services	\$2,000 per individual per benefit period \$1,000 per lifetime <b>NOTE:</b> Two (2) payments for orthodontic services of up to \$500 in a calendar year during each of <b>two (2) separate calendar years</b> of the <b>Covered Person's</b> lifetime (maximum of \$1,000). Orthodontic benefits also count toward the calendar year maximum. No more than \$2,000 will be paid by the Plan for any combination of orthodontic or non-orthodontic expenses incurred in the same calendar year for each <b>Covered Person</b> .
<b>Class I – Diagnostic &amp; Preventive Dental Services</b> Exams – 2 every calendar year Prophylaxis – 2 every calendar year Full Mouth X-ray - 1 every 36 months Bitewings – 2 every calendar year Panoramic – 1 every 36 months, with or without full mouth x-rays/complete series Periapical X-rays Fluoride - under age 19 - 1 every calendar year Space Maintainers – 1 every 3 consecutive years Sealants - under age 15 - 1 per tooth every 3 consecutive years	80% after deductible
<b>Class II – Basic Dental Services</b> Emergency Exams/Palliative Treatment Tests and Laboratory examinations Prescribed medications Basic Restorations/Fillings (resin, silicate, plastic, amalgam or composite fillings) Crown and prosthetic repairs Endodontics Periodontics Oral surgery/Exactions – Simple, surgical, impacted, cyst/tumor removal General Anesthetic Prosthetic repairs Consultations	80% after deductible
<b>Class III – Major Dental Services</b> Major Restorations/Fillings (precious metal fillings) Crowns Inlays/Onlays Bridgework Partial/Full Dentures Reline/Rebase Dentures <b>There is a 5 year replacement rule.</b>	60% after deductible
<b>Class IV – Orthodontic Services</b>	60% after deductible

# PREFERRED PROVIDER OR NONPREFERRED PROVIDER

*Covered persons* have the choice of using either a *preferred provider* or a *nonpreferred provider*.

## **PREFERRED PROVIDER**

A *preferred provider* is a *physician, hospital* or ancillary service provider which has an agreement in effect with the *Preferred Provider Organization* (PPO) to accept a *negotiated rate* for services rendered to *covered persons*. In turn, the PPO has an agreement with the *plan administrator* or CoreSource to allow access to *negotiated rates* for services rendered to *covered persons*. The PPO's name and/or logo is shown on the front of the *covered person's* ID card. The *preferred provider* cannot bill the *covered person* for any amount in excess of the *negotiated rate* for *covered expenses*. *Covered persons* should contact the *employer's* Human Resources Department, contact CoreSource's customer service department, or review the PPO's website for a current listing of *preferred providers*.

## **NONPREFERRED PROVIDER**

A *nonpreferred provider* does not have an agreement in effect with the *Preferred Provider Organization*. When a *covered person* receives care outside of the Anthem Service Area and that care is not subject to the Inter-Plan Arrangements, the amount allowed for such care will be based on the *fair allowable amount*. This may result in greater out of pocket expenses to the covered person. ^C When a *covered person* receives care outside of the Anthem Service Area, this *Plan* covers limited healthcare services received outside of the Anthem Service Area. For example, *emergency services* obtained outside the Anthem Service Area are always covered. Any other healthcare service will not be covered when processed through any Inter-Plan Arrangements.

*Covered expenses* for *emergency services* by a *nonpreferred provider* shall be paid at the greatest of the following three amounts: the amount negotiated with *preferred providers* for such *covered expenses*, the amount determined as the *customary and reasonable amount*, or the amount that would be paid under *Medicare* for such *emergency services*.

## **REFERRALS**

Referrals to a *nonpreferred provider* are covered as *nonpreferred provider* services, supplies and treatments. It is the responsibility of the *covered person* to assure services to be rendered are performed by *preferred providers* in order to receive the *preferred provider* level of benefits.

## **EXCEPTIONS**

The following listing of exceptions represents services, supplies or treatments rendered by a *nonpreferred provider* where *covered expenses* shall be payable at the *preferred provider* level of benefits:

1. *Emergency services* rendered at a *nonpreferred provider facility* or at a *preferred provider facility* by a *nonpreferred provider*. If the *covered person* is admitted to the *hospital* on an *emergency* basis, *covered expenses* shall be payable at the *preferred provider* level. The in-network benefit will continue for the duration of the hospitalization.
2. *Nonpreferred* anesthesiologist when the *facility* where such services are rendered is a *preferred provider*.
3. *Nonpreferred* assistant surgeon if the operating surgeon is a *preferred provider*.

4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a ***nonpreferred provider*** when the ***facility*** where such services are rendered is a ***preferred provider***.
5. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***.
6. While the ***covered person*** is confined to a ***preferred provider hospital***, the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider***, or a newborn visit is performed by a ***nonpreferred provider***.
7. ***Medically necessary*** specialty services, supplies or treatments which are not available from a provider within the ***Preferred Provider Organization***.
8. Treatment rendered at a ***facility*** of the uniformed services.
9. Transportation by a ***nonpreferred provider*** ambulance for a condition that meets the definition of ***emergency***.
10. Lactation counseling providers.

# MEDICAL EXPENSE BENEFIT

This section describes the *covered expenses* of the *Plan*. All *covered expenses* are subject to applicable *Plan* provisions including, but not limited to: deductible, *copay*, *coinsurance* and *maximum benefit* provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense *incurred* by the *covered person* for services, supplies or treatment, which is greater than the *customary and reasonable amount* for *nonpreferred providers* or *negotiated rate* for *preferred providers* will not be considered a *covered expense* by the *Plan*. Specified preventive care expenses will be considered to be *covered expenses*.

## ***COPAY***

The *copay* is the amount payable by the *covered person* for certain services, supplies or treatment rendered by a *professional provider*. The service and applicable *copay* are shown on the *Schedule of Benefits*. The *covered person* selects a *professional provider* and pays the applicable *copay*. The *Plan* pays the remaining *covered expenses* at the *negotiated rate* for *preferred providers* or the *customary and reasonable amount* for *nonpreferred providers*. The *copay* must be paid each time a treatment or service is rendered.

The *copay* will not be applied toward the calendar year deductible.

## ***DEDUCTIBLES***

### *Individual Deductible*

The individual deductible is the dollar amount of *covered expense* which each *covered person* must have *incurred* during each calendar year before the *Plan* pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

### *Family Deductible*

If there are other family members in this *Plan*, they have to meet their own individual deductible until the overall family deductible amount has been met.

### *Common Accident*

If two or more covered members of a family are *injured* in the same *accident* and, as a result of that *accident*, incur *covered expenses*, only one (1) individual deductible amount will be deducted from the total *covered expenses* of all covered family members related to the accident for the remainder of the calendar year.

## ***COINSURANCE***

The *Plan* pays a specified percentage of *covered expenses* as the *customary and reasonable amount* for *nonpreferred providers*, or the percentage of the *negotiated rate* for *preferred providers*. That percentage is specified on the Schedule of Benefits. For *nonpreferred providers*, the *covered person* is responsible for the difference between the percentage the *Plan* paid and one hundred percent (100%) of the billed amount.

## ***OUT-OF-POCKET EXPENSE LIMIT***

After the *covered person* has incurred an amount equal to the *preferred provider* out-of-pocket expense limit listed on the *Schedule of Benefits* for *covered expenses*, the *Plan* will begin to pay one hundred percent (100%) of *covered expenses* for the remainder of the calendar year.

If there are other family members in this *Plan*, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

#### *Out-of-Pocket Expense Limit Exclusions*

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by the *Plan*, to include charges in excess of the *customary and reasonable amount* or *negotiated rate*, as applicable.
2. Expenses incurred as a result of failure to obtain pre-certification.

### **MAXIMUM BENEFIT**

The *Schedule of Benefits* may contain separate *maximum benefit* limitations for specified conditions and/or services. Any separate *maximum benefit* will include all such benefits paid by the *Plan* for the *covered person* during any and all periods of coverage under the *Plan*. No more than the *Essential Health Benefits/non-Essential Health Benefits maximum benefit* will be paid for any *covered person* while covered by the *Plan*.

Notwithstanding any provision of the *Plan* to the contrary, all benefits received by an individual under any benefit option, package or coverage under the *Plan* shall be applied toward the applicable *maximum benefit* paid by the *Plan* for any one *covered person* for such option, package or coverage under the *Plan*, and also toward the *maximum benefit* under any other options, packages or coverages under the *Plan* in which the individual may participate in the future.

### **HOSPITAL/AMBULATORY SURGICAL FACILITY**

*Covered expenses* shall include:

1. *Room and board* for treatment in a *hospital*, including *intensive care units*, cardiac care units and similar *medically necessary* accommodations. *Covered expenses* for *room and board* shall be limited to the *hospital's semiprivate* rate. *Covered expenses* for *intensive care* or cardiac care units shall be the *customary and reasonable amount* for *nonpreferred providers* and the percentage of the *negotiated rate* for *preferred providers*. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the *covered person*.
2. Miscellaneous *hospital* services, supplies, and treatments including, but not limited to:
  - a. Admission fees, and other fees assessed by the *hospital* for rendering services, supplies and treatments;
  - b. Use of operating, treatment or delivery rooms;
  - c. Anesthesia, anesthesia supplies and its administration by an employee of the *hospital*;
  - d. Medical and surgical dressings and supplies, casts and splints;
  - e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
  - f. Drugs and medicines (except drugs not used or consumed in the *hospital*);
  - g. X-ray and diagnostic laboratory procedures and services;
  - h. Oxygen and other gas therapy and the administration thereof;
  - i. Therapy services.
3. Services, supplies and treatments described above furnished by an *ambulatory surgical facility*, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) performed prior to a **hospital** admission which are related to the condition which is necessitating the **confinement**. Such tests shall be payable even if they result in additional medical treatment prior to **confinement** or if they show that **hospital confinement** is not **medically necessary**. Such tests shall not be payable if the same tests are performed again after the **covered person** has been admitted.

## ***AMBULANCE SERVICES***

***Covered expenses*** shall include:

1. Ambulance services for air or ground transportation for the **covered person** from the place of **injury** or serious medical incident to the nearest **hospital** where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the **covered person** to or from a **hospital** or between **hospitals** for required treatment when such transportation is certified by the attending **physician** as **medically necessary**. Such transportation is covered only from the initial **hospital** to the nearest **hospital** qualified to render the special treatment.
3. **Emergency** services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the **covered person** is admitted to a **nonpreferred hospital** after **emergency** treatment, ambulance service is covered to transport the **covered person** from the **nonpreferred hospital** to a **preferred hospital** after the patient's condition has been stabilized, provided such transport is certified by the attending **physician** as **medically necessary**.

## ***EMERGENCY SERVICES/EMERGENCY ROOM SERVICES***

***Covered expenses*** for **emergency services** in the emergency department of a **hospital** shall be paid in accordance with the *Schedule of Benefits*. **Emergency services** by a **nonpreferred provider** shall be paid as specified in the section, *Preferred Provider or Nonpreferred Provider*, under the subsection, *Nonpreferred Provider*.

Emergency room treatment for conditions that do not meet the definition of **emergency** will be considered non-**emergency** use of the emergency room and will be subject to the benefits as shown on the *Schedule of Benefits*

Any applicable emergency room **copay** shall be waived if the patient is admitted directly into the **hospital**.

## ***URGENT CARE CENTER***

***Covered expenses*** shall include charges for treatment in an **urgent care center**, payable as specified on the *Schedule of Benefits*.

## ***ACCIDENT EXPENSE BENEFIT***

Initial treatment and follow-up care within ninety (90) days of an **injury** will be payable, subject to any applicable **maximum benefit**, as specified in the *Schedule of Benefits*.

## ***PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES***

***Covered expenses*** shall include the following services when performed by a **physician** or a **professional provider**:

1. Medical treatment, services and supplies including, but not limited to: office visits, **inpatient** visits, home visits.

2. Surgical treatment. Separate payment will not be made for *inpatient* pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, *covered expenses* shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.

When two (2) or more unrelated operations or procedures are performed in the same operative session, covered expenses shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a *physician* or *professional provider* if it is determined that the condition of the *covered person* or the type of surgical procedure requires such assistance. *Covered expenses* for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.
5. Consultations requested by the attending *physician* during a *hospital confinement*. Consultations do not include staff consultations that are required by a *hospital's* rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

## ***SECOND SURGICAL OPINION***

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the *physician*.

The *physician* rendering the second opinion regarding the *medical necessity* of such surgery must be a board certified specialist in the treatment of the *covered person's illness* or *injury* and must not be affiliated in any way with the *physician* who will be performing the actual surgery.

In the event of conflicting opinions, a third opinion may be obtained. The *Plan* will consider payment for a third opinion the same as a second surgical opinion.

The second surgical opinion benefit includes *physician* services only. Any diagnostic services will be payable under the standard provisions of the *Plan*.

In the event a second surgical opinion is not recommended by the *Health Care Management Organization* or by the *Plan*, the *covered person* may choose to seek an elective second surgical opinion; however, benefits will be paid as specified on the *Schedule of Benefits*.

## ***DIAGNOSTIC SERVICES AND SUPPLIES***

*Covered expenses* shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

## ***TRANSPLANT***

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under the ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.
2. When the donor is covered under the ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under the ***Plan***. ***Covered expenses incurred*** by each person will be considered separately for each person.
3. Expenses ***incurred*** by the donor who is not ordinarily covered under the ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under the ***Plan***. The donor's expenses shall be applied to the recipient's ***maximum benefit***. In no event will benefits be payable in excess of the ***maximum benefit***.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under the ***Plan***.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

*Centers of Medical Excellence Program*

### **Types of Providers**

The ***claims administrator*** is providing access to the following separate ***Centers of Medical Excellence (CME)*** networks. The facilities included in each of these ***CME*** networks are selected to provide the following specified medical services:

**Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable copays or deductibles, ***CME*** have agreed to a rate they will accept as payment in full for covered services.

## ***PREGNANCY***

***Covered expenses*** shall include services, supplies and treatment related to ***pregnancy*** or ***complications of pregnancy*** for a covered female ***employee/retiree***, a covered female spouse of a covered ***employee/retiree***, and ***dependent*** female children.

Complications from an abortion shall be a ***covered expense*** whether or not the abortion is a ***covered expense***.

## ***BIRTHING CENTER***

***Covered expenses*** shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

## ***STERILIZATION***

*Covered expenses* shall include elective surgical sterilization procedures for the covered male *employee/retiree* or covered male spouse. Reversal of surgical sterilization is not a *covered expense*. *Covered expenses* for elective surgical sterilization procedures for women shall be considered under the subsection, *Women's Preventive Services*.

## ***INFERTILITY SERVICES***

Coverage is limited to AI (artificial insemination), IUI (intra-uterine insemination) or IVF (in-vitro fertilization) when needed due to medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to infertility. Coverage is available up to a maximum of six (6) ovulatory cycles per course of treatment when rendered within two (2) consecutive years. To obtain coverage approval for a course of AI, IUI or IVF, the *Physician* must provide a statement of medical necessity including details on condition, medical history, previous infertility or AI/IUI/IVF treatment and proposed treatment plan. The *Claims processor* will advise whether coverage is available according to *Plan* limitations and exclusions. Any combination of AI/IUI/IVF will only be reimbursed up to the value of six (6) cycles of AI/IUI in two (2) years. Any amounts exceeding this value will be the responsibility of the member. Benefits are limited to the following:

1. Initial course of AI/IUI/IVF up to six (6) ovulatory cycles within two (2) years.
2. If the treatment course is not successful (does not result in confirmed *pregnancy*), benefits will be considered exhausted. Coverage will not be available for subsequent AI/IUI/IVF expenses.
3. If the initial course of treatment is successful (results in confirmed *pregnancy*) within six (6) cycles, coverage becomes available for a second course of AI/IUI/IVF treatment. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent AI/IUI/IVF treatment.
4. Exhausted coverage or benefits is for a lifetime.

Benefits for the resulting *pregnancy* will be considered separately as maternity care. However, expenses related to surrogate maternity care are not covered. Expenses related to the procurement of sperm donated by the patient's spouse are covered only when part of an approved course of treatment for AI/IUI/IVF. If services are not part of an approved course of treatment, the procurement expenses are not covered, whatever the reason. Coverage is not provided for infertility or artificial conception services and supplies related to surrogate pregnancies. Expenses related to freezing and storage of sperm are not covered, whatever the reason. Reproductive coverage is limited to AI/IUI/IVF shown above. **Coverage is not provided for other care such as fertility or infertility care or other treatment rendered for the purpose of reproduction.** However, surgical or medical procedures directed at treatment of an identifiable organic disease or organic disorder will be considered the same as any other illness.

## ***CONTRACEPTIVES***

FDA approved contraceptive methods shall be considered under the subsection, *Women's Preventive Services*.

## ***WELL NEWBORN CARE***

The *Plan* shall cover well newborn care while the mother is confined for delivery. *Covered expenses* for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and *coinsurance* from the mother.

Such care shall include, but is not limited to:

1. *Physician* services
2. *Hospital* services

3. Circumcision

## ***ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS***

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Annual routine mammograms for women as recommended by the United States Preventive Services Task Force (USPSTF).
3. Colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam, for adults.
4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention.
5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.
6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a *physician*.

The *Plan* will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

## ***WOMEN'S PREVENTIVE SERVICES***

*Covered expenses* shall include the following preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration:

1. Annual well-woman office visits to obtain preventive care;
2. Screening for gestational diabetes in a pregnant woman;
3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;
4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity;
7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment; and
8. Annual screening and counseling for interpersonal and domestic violence.
9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

The *Plan* will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive *item* or service to the extent that such techniques are not specified in the recommendations or guidelines.

***The Plan will not provide coverage for the above referenced women's preventive services until the Plan year that begins on or after one year after the date such recommendation or guideline referenced above is issued.***

## ***ROUTINE PROSTATE EXAMINATIONS***

***Covered expenses*** shall include one (1) routine prostate examination per calendar year, for men age forty (40) and over.

## ***THERAPY SERVICES***

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury*** or for congenital anomaly.

***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.

## ***EXTENDED CARE FACILITY***

***Extended care facility*** services, supplies and treatments shall be a ***covered expense*** provided the ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

***Covered expenses*** shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and
2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

## ***HOME HEALTH CARE***

***Home health care*** enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include the following services and supplies provided by a ***home health care agency***:

1. Part-time or intermittent nursing care by a ***nurse***;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

A visit by a member of a *home health care* team and four (4) hours of *home health aide service* will each be considered one (1) *home health care* visit.

No *home health care* benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of *durable medical equipment* or prescription or non-prescription drugs or biologicals.

## ***HOSPICE CARE***

*Hospice* care is a health care program providing a coordinated set of services rendered at home, in *outpatient* settings, or in *facility* settings for a *covered person* suffering from a condition that has a terminal prognosis.

*Hospice* care will be covered only if the *covered person's* attending *physician* certifies that:

1. The *covered person* is terminally ill, and
2. The *covered person* has a life expectancy of six (6) months or less.

*Covered expenses* shall include:

1. *Confinement* in a *hospice* to include ancillary charges and *room and board*.
2. Services, supplies and treatment provided by a *hospice* to a *covered person* in a home setting.
3. *Physician* services and/or nursing care by a *nurse*.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be *medically necessary*.
6. Counseling services provided through the *hospice*.
7. Bereavement counseling as a supportive service to *covered persons* in the terminally ill *covered person's* immediate family.

Charges *incurred* during periods of remission are not eligible under this provision of the *Plan*. Any *covered expense* paid under *hospice* benefits will not be considered a *covered expense* under any other provision of the *Plan*.

## ***DURABLE MEDICAL EQUIPMENT***

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), of *medically necessary durable medical equipment* which is prescribed by a *physician* and required for therapeutic use by the *covered person* shall be a *covered expense*.

A charge for the purchase or rental of *durable medical equipment* is considered *incurred* on the date the equipment is received/delivered. *Durable medical equipment* that is received/delivered after the termination date of a *covered person's* coverage under the *Plan* is not covered. Repair or replacement of purchased *durable medical equipment* which is *medically necessary* due to normal use or a physiological change in the patient's condition will be considered a *covered expense*.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the **covered person's** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the **covered person's** medical needs.

Ongoing rental charges for oxygen concentrators shall be a **covered expense**, provided the equipment is determined to be **medically necessary** for the treatment of chronic conditions or upon diagnosis of severe lung disease or other hypoxia related symptoms or findings.

**Covered expenses** for the rental or purchase, whichever is less costly, of breastfeeding equipment shall be considered under the subsection, *Women's Preventive Services*.

## ***PROSTHESES***

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a **covered expense**. A charge for the purchase of a prosthesis is considered **incurred** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a **covered person's** coverage under the **Plan** is not covered. Repair or replacement of a prosthesis which is **medically necessary** due to normal use or a physiological change in the patient's condition will be considered a **covered expense**.

## ***ORTHOTICS***

Orthotic devices and appliances (a rigid or semi-rigid supportive device, including custom/molded foot orthotics, which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a **covered expense**. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

## ***DENTAL SERVICES***

**Covered expenses** shall include repair of sound natural teeth or surrounding tissue provided it is the result of an **injury**. Treatment must begin within twelve (12) months from the date of such **injury**. Damage to the teeth as a result of chewing or biting shall not be considered an **injury** under this benefit.

**Covered expenses** shall include charges for oral surgery such as closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

**Facility** charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the **covered person** has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

## ***SPECIAL EQUIPMENT AND SUPPLIES***

**Covered expenses** shall include **medically necessary** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; syringes and needles for diabetes; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of **illness** or **injury** of the eye; support stockings, such as Jobst stockings; a wig or hairpiece when required due to chemotherapy, surgery or burns, limited to one (1) while covered by the **Plan**; surgical dressings and other medical supplies ordered by a **professional provider** in connection with medical treatment, but not common first aid supplies.

## ***COSMETIC/RECONSTRUCTIVE SURGERY***

*Cosmetic surgery* or *reconstructive surgery* shall be a *covered expense* provided:

1. A *covered person* receives an *injury* as a result of an *accident* and as a result requires surgery. *Cosmetic* or *reconstructive surgery* and treatment must be for the purpose of restoring the *covered person* to his normal function immediately prior to the *accident*.
2. It is required to correct a congenital anomaly, for example, a birth defect.

## ***MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)***

The *Plan* intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

*Covered expenses* will include eligible charges related to *medically necessary* mastectomy.

For a *covered person* who elects breast reconstruction in connection with such mastectomy, *covered expenses* will include:

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and *medically necessary* replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered *covered expenses* following all *medically necessary* mastectomies.

## ***MENTAL & NERVOUS DISORDERS***

The *Plan* will pay for *medically necessary covered expenses* for *inpatient* and *outpatient* treatment, services or supplies for the treatment of *mental and nervous disorders*.

*Covered expenses* shall include:

1. *Inpatient hospital confinement*;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same *professional provider*.

## ***CHEMICAL DEPENDENCY CARE***

The *Plan* will pay for *medically necessary covered expenses* for the *inpatient* and *outpatient* treatment of *chemical dependency* in a *hospital* or *treatment center* by a *physician* or *professional provider*.

## ***ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS***

***Covered expenses*** shall include charges for “routine patient costs” incurred by a “qualified individual” participating in an ***approved clinical trial***. “Routine patient costs” do not include:

1. An investigational item, device or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“Life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“Qualified Individual” means a ***covered person*** who is eligible to participate in an ***approved clinical trial*** according to the trial protocol with respect to the treatment of cancer or another “life-threatening disease or condition” and either;

1. The referring health care professional has concluded that the ***covered person’s*** participation in such trial would be appropriate; or,
2. The ***covered person*** provides medical and scientific information establishing that the ***covered person’s*** participation in such trial would be appropriate.

“Routine patient costs” include all items and services consistent with the coverage provide by the ***Plan*** that is typically covered for a ***covered person*** who is not enrolled in a clinical trial.

## ***OFF-LABEL DRUG USE***

***Covered expenses*** shall include charges for the use of an FDA-approved drug for a purpose other than that for which it is approved, but only when the drug is not excluded by the ***Plan*** and the ***plan sponsor*** determines in its sole discretion that the drug is appropriate and generally accepted for the condition being treated, subject to any ***maximum benefit*** shown on the ***Schedule of Benefits***.

## ***PHASE III ONCOLOGY CLINICAL TRIALS***

***Covered expenses*** shall include charges for a drug, device, supply, treatment, procedure or service that is part of a scientific study of cancer therapy in a Phase III clinical trial sponsored by the National Cancer Institute or institution of similar stature subject to any ***maximum benefit*** shown on the ***Schedule of Benefits***. Trials must have Institutional Review Board (IRB) approval by a qualified IRB. Charges that are not covered include:

1. Costs for services that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
2. Costs for services provided in a clinical trial that are funded by another source.

## ***PODIATRY SERVICES***

***Covered expenses*** shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

## ***CHIROPRACTIC CARE***

*Covered expenses* include initial consultation, x-rays and treatment (but not maintenance care).

## ***PATIENT EDUCATION***

*Covered expenses* shall include *medically necessary* patient education programs including, but not limited to diabetic education and ostomy care. *Covered expenses* for patient education for contraception or lactation training shall be considered under the subsection, *Women's Preventive Services*.

## ***SURCHARGES***

Any surcharge or assessment (by whatever name called) on *covered expenses*, required by state or federal law to be paid by the *Plan* for services, supplies and/or treatments rendered by a health care provider shall be a *covered expense* subject to the *covered person's* obligations under the *Plan*.

## ***OUTPATIENT CARDIAC /PULMONARY REHABILITATION PROGRAMS***

*Covered expenses* shall include charges for qualified *medically necessary outpatient* cardiac /pulmonary rehabilitation programs.

## ***SURGICAL TREATMENT OF MORBID OBESITY***

*Covered expenses* shall include charges for surgical treatment of *morbid obesity* for *covered persons* with health problems that are aggravated by or related to the *morbid obesity*, including, but not limited to gastric by-pass, gastric stapling or gastric balloon when determined to be *medically necessary*.

## ***NON-SURGICAL TREATMENT OF MORBID OBESITY***

*Covered expenses* shall include charges for weight-loss programs that are administered and supervised by a *hospital* or *physician's* clinic to treat a medical condition by a decrease in the patient's weight. This program must not be a weight reduction program, but a program designed to treat health problems associated with high-risk *morbid obesity*. These health conditions may include hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease. The patient must have demonstrated unsuccessful results in a weight loss program. Coverage is limited to *medically necessary* charges for treatment of *morbid obesity*.

## ***SLEEP DISORDERS***

*Covered expenses* shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

# PLAN EXCLUSIONS

The *Plan* will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *physician* or *professional provider*, unless otherwise stated.

**Abortion** - Charges for services provided to a *covered person* for an elective or voluntary abortion. However, complications from such procedure shall be a *covered expense* for a covered female *employee/retiree* or the covered female spouse of an *employee/retiree*.

**Blood** - Charges for procurement and storage of one's own blood, unless *incurred* within three (3) months prior to a scheduled surgery.

**Comfort Items** - Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a *physician*, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

**Complications** - Charges *incurred* as a result of, or in connection with, any procedure or treatment excluded by the *Plan* which has resulted in medical complications, except for complications from a non-covered abortion as specified herein.

**Cosmetic** - Expenses for a *cosmetic surgery* or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic/Reconstructive Surgery*.

**Counseling** - Charges for marriage, career or legal counseling.

**Crime** - Charges in connection with any *illness* or *injury* of the *covered person* resulting from or occurring during the *covered person's* commission or attempted commission of a criminal battery or felony. Claims shall be denied if the *plan administrator* has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the *covered person*. This exclusion will not apply to an *illness* and/or *injury* sustained due to a medical condition (physical or mental) or domestic violence.

**Custodial Care** - Charges for *custodial care*, domiciliary care or rest cures.

**Dental** - Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of *injury* or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

**Developmental Delay** - Charges for services, supplies or treatment for behavior or conduct disorders, development delay, or learning disorders. However, the initial examination, office visit and diagnostic testing to determine the *illness* shall be a *covered expense*.

**Donor, transplant** - Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a *covered person* under the *Plan*.

**Education** - Except as specified herein, charges for services, supplies or treatments which are primarily educational in nature, charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

**Effective Date** - Charges for services rendered and/or supplies received prior to the *effective date* or after the termination date of a person's coverage, except as specifically provided herein.

**Employment** - Charges for employment physicals, or any related charges, such as premarital lab work.

**Exercise Programs** - Charges for exercise programs for treatment of any condition, except as specified herein.

**Experimental/Investigational** - Charges for drugs, devices, supplies, treatments, procedures or services that are considered *experimental/investigational* by the *Plan*. The *Plan* will consider a drug, device, supply, treatment, procedure or service to be “*experimental*” or “*investigational*”:

- a. if, in the case of a device or supply, the device or supply 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 device or supply is furnished; or
- b. if the drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service 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
- c. if the *plan sponsor* (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service 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 maximum tolerated dose, toxicity, safety or efficacy, however, a drug, device, supply, treatment, procedure or service that meets the standards set in the section *Medical Expense Benefit Phase III Oncology Clinical Trials* or *Off-Label Drug Use* will not be deemed *experimental* or *investigational* solely by reason of this subparagraph; or
- d. if the *plan sponsor* (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

**Foot Care** - Except as *medically necessary* for the treatment of metabolic or peripheral-vascular *illness*, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

**Foreign** - Charges *incurred* outside the United States if the *covered person* traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

**Gender Dysphoria** - Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

**Hair** - Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or stimulate hair growth, except as specified herein.

**Hearing** - Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss, or surgery to implant such a device. FDA cochlear implants are covered.

**Holistic Medicines** - Charges for holistic medicines or providers of naturopathy.

**Hypnosis** - Charges for expenses related to hypnosis.

**Infertility** - Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: surrogate mother, and fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT). Coverage is limited to AI (artificial insemination), IUI (intra-uterine insemination) or IVF (in-vitro fertilization) when needed due to medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to infertility.

**Law** - To the extent that payment under the *Plan* is prohibited by any law of any jurisdiction in which the *covered person* resides at the time the expense is *incurred*.

**License** - Charges for services, supplies or treatment rendered by *physicians* or *professional providers* beyond the scope of their license; for any treatment, *confinement* or service which is not recommended by or performed by an appropriate *professional provider*.

**Massage** - Charges for massage therapy, sex therapy, or recreational therapy.

**Medically Necessary** – Charges made for services, supplies and treatment which are not *medically necessary* for the treatment of *illness* or *injury*, or which are not recommended and approved by the attending *physician*, except as specifically stated herein, or to the extent that the charges exceed *customary and reasonable amount* or exceed the *negotiated rate*, as applicable.

**Military** - Charges for an *injury* sustained or *illness* contracted while on active duty in military service, unless payment is legally required.

**Orthotics** - Orthotics or other foot devices and supports used for foot disorders, except when needed after an open cutting surgical procedure.

**Orthopedic Shoes** - Charges for orthopedic shoes or shoe inserts.

**Overlapping Coverage** - Benefits which are payable under any one section of the *Plan* shall not be payable as a benefit under any other section of the *Plan*. For example, if a benefit is eligible under both the *Medical Expense Benefit* section and the *Dental Expense Benefit* section, and is paid under the *Medical Expense Benefit*, the remaining balance will **not** be paid under the *Dental Expense Benefit*.

**Primary Coverage** - If the primary plan has a restricted list of healthcare providers and the *covered person* chooses not to use a provider from the primary plan's restricted list, this *Plan* will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits. This *Plan* will not pay for any charge which has been refused by another plan covering the *covered person* as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

**Private Duty Nursing** – Charges for inpatient private duty nursing.

**Relatives** - Charges for services, supplies or treatment rendered by any individual who is a *close relative* of the *covered person* or who resides in the same household as the *covered person*.

**Reversal of Sterilization** - Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

**School, Sports** - Charges for sports physicals, or preschool or school examinations.

**Smoking Cessation** - Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

**Structural Changes** - Charges for structural changes to a house or vehicle.

**Temporomandibular Joint Dysfunction (TMJ)** – Charges for treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome.

**Third Party Liability** - Charges for *illnesses* or *injuries* suffered by a *covered person* due to the action or inaction of any party if the *covered person* fails to provide information as specified in the section, *Subrogation/Reimbursement*.

**Timely Filing** - Claims not submitted within the *Plan's* filing limit deadlines as specified in the section, *Claim Filing Procedure*.

**Transplants** – Charges for transportation, lodging and meals.

**Travel** - Charges for travel or accommodations, whether or not recommended by a *physician*, except as specifically provided herein.

**Travel, Immunizations** - Charges for immunizations required for travel.

**Vision** - Charges for routine vision examinations and eye refractions; eyeglasses or contact lenses; dispensing optician's services, except as specified herein. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

**Vitamins/Supplements** - Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

**War** - Charges for services, treatment or supplies for treatment of *illness* or *injury* which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

**Weight Reduction Programs** - Charges for non-surgical services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and *hospital confinements* for weight reduction programs, except as specifically provided herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

**Workers' Compensation** - Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the *covered person* fails to claim rights to such benefits or fails to enroll or purchase such coverage. Charges in connection with any *illness* or *injury* arising out of or in the course of any employment intended for wage or profit, including self-employment.

# PRESCRIPTION DRUG PROGRAM

## ***PHARMACY OPTION***

*Participating pharmacies* have contracted with the *Plan* to charge *covered persons* reduced fees for covered prescription drugs.

## ***PHARMACY OPTION COPAY OR COINSURANCE***

The *copay* or *coinsurance* is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The *copay* or *coinsurance* amount is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to the greater of thirty-four (30) day supply or a one hundred (100) unit dose. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If a drug is purchased from a *participating pharmacy* when the *covered person's* ID card is not used, the *covered person* must pay the entire cost of the prescription, including *copay*, and then submit the receipt to the prescription drug card vendor for reimbursement.

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the *generic drug* and the brand name requested, plus the usual *copay* or *coinsurance*. The *covered person* may appeal the adverse benefit determination. This difference between the cost of the brand name drug and the *generic drug* shall not accumulate toward the out-of-pocket limit.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

Drugs purchased from a *nonparticipating pharmacy* are not covered.

## ***MAIL ORDER OPTION***

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

## ***MAIL ORDER OPTION COPAY OR COINSURANCE***

The *copay* is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The *copay* is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the *generic drug* and the brand name requested, plus the usual *copay* or *coinsurance*.

Drugs purchased from a *nonparticipating pharmacy* are not covered.

## ***COVERED PRESCRIPTION DRUGS***

1. Drugs prescribed by a *physician* that require a prescription either by federal or state law except drugs excluded by the *Plan*.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, insulin needles and syringes and diabetic supplies.

4. Oral contraceptives, regardless of the reason prescribed.
5. Oral drugs used in the treatment of erectile dysfunction (with prior authorization).
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a *qualified prescriber*.
7. Routine preventive drugs as required by the Affordable Care Act.
8. Acne products (including Tretinoins).

### ***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***

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or routine preventive drugs as required by the Affordable Care Act.
2. 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.
3. Immunization agents or biological sera, blood or blood plasma.
4. A drug or medicine labeled: "Caution - limited by federal law to *investigational* use."
5. *Experimental* drugs and medicines, even though a charge is made to the *covered person*.
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the *covered person*, in whole or in part, while *hospital* confined. This includes being confined in any institution that has a *facility* for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.
12. A charge for infertility medication without prior authorization.
13. A charge for contraceptive devices.
14. A charge for legend vitamins, except pre-natal legend vitamins.
15. A charge for minerals.

16. A charge for fluoride supplements, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.
17. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).
18. A charge for growth hormones.
19. A charge for weight loss drugs.
20. A charge for Levonorgestrel (Norplant implants).
21. A charge for Hematinics.
22. A charge for drugs used in the treatment of erectile dysfunction, except oral drugs with prior authorization.
23. A charge for non-legend drugs, other than as specifically listed herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.
24. A charge for over the counter products.

### ***NOTICE OF AUTHORIZED REPRESENTATIVE***

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

## ***APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM***

The "***named fiduciary***" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
  - a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
  - b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***named fiduciary*** will not afford deference to the original denial.
6. The ***named fiduciary*** will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
  - a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
  - b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

## ***NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL***

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.

5. A statement that if the **covered person's** appeal is denied, the **covered person** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on **medical necessity, experimental/investigational** treatment or similar exclusion or limit, the **plan administrator** (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## ***EXTERNAL APPEAL***

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the **named fiduciary** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. **Medical necessity**;
2. Appropriateness;
3. **Experimental** or **investigational** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a **covered expense**.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1<sup>st</sup> falls on a Saturday, Sunday or Federal holiday.*}

## ***RIGHT TO EXTERNAL APPEAL***

Within five (5) business days of receipt of the request, the **claims processor** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this **Plan**.

## ***NOTICE OF RIGHT TO EXTERNAL APPEAL***

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the **covered person** to perfect the external review request by the later of the following:
  - a. The four (4) month filing period; or
  - b. Within the forty-eight (48) hour time period following the **covered person's** receipt of notification.

## ***INDEPENDENT REVIEW ORGANIZATION***

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

## ***NOTICE OF EXTERNAL REVIEW DETERMINATION***

The assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***claims processor***, except to the extent that other remedies may be available under State or Federal law.

## ***EXPEDITED EXTERNAL REVIEW***

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the final denial involves any of the following:
  - a. An admission,
  - b. Availability of care,
  - c. Continued stay, or
  - d. A health care item or service for which the ***covered person*** received ***emergency services***, but has not yet been discharged from a ***facility***.

Immediately upon receipt of the request for *Expedited External Review*, the ***Plan*** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
2. Send notice of the ***Plan's*** decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the ***Plan*** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the ***covered person's*** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

# DENTAL EXPENSE BENEFIT

Subject to all the terms of the *Plan*, the *Plan* will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the *customary and reasonable amount* for covered dental expenses, as shown on the *Schedule of Benefits*.

## DEDUCTIBLE

### *Individual Deductible*

The individual deductible is the dollar amount of *covered expense* which each *covered person* must incur during each calendar year before the *Plan* pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

### *Family Deductible*

If, in any calendar year, covered members of a family incur *covered expenses* that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

### *Common Accident*

If two or more covered members of a family are *injured* in the same *accident* and, as a result of that *accident*, incur *covered expenses*, only one (1) individual deductible amount will be deducted from the total *covered expenses* of all covered family members related to the accident for the remainder of the calendar year.

## COINSURANCE

The *Plan* pays a specified percentage of the *customary and reasonable amount* for *covered expenses*. That percentage is listed on the *Schedule of Benefits*. The *covered person* is responsible for the difference.

## MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a *covered person* for covered dental expense is stated on the *Schedule of Benefits*. If the *covered person's* coverage under the *Plan* terminates and he subsequently returns to coverage under the *Plan* during the calendar year, the *Essential Health Benefit maximum benefit* for a *covered person* under age eighteen (18) and the non-*Essential Health Benefit maximum benefit* for a *covered person* age eighteen (18) and older will be calculated on the sum of benefits paid by the *Plan*.

The non-*Essential Health Benefits maximum benefit* for orthodontic treatment while a *covered person* is covered by the *Plan* is also specified on the *Schedule of Benefits*. If the *covered person* receives more than one course of orthodontic treatment while covered by the *Plan* and if it can be clearly shown that any later course of treatment is not a part of a previous course of treatment, then the *covered person* will be entitled to a separate non-*Essential Health Benefits maximum benefit* for each course of treatment.

## ALTERNATIVE TREATMENT

In the event the *dentist* recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the *covered person's* choice to obtain the higher-cost treatment will be the *covered person's* responsibility.

## ***DENTAL INCURRED DATE***

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred***, except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

## ***COVERED DENTAL EXPENSES***

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

### *Class I Diagnostic and Preventive Dental Services*

1. Routine oral examination: Initial or periodic, limited to twice per calendar year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.
3. Dental x-rays as follows:
  - a. Supplementary bite-wing x-rays, limited to twice per calendar year.
  - b. Panorex and/or full mouth series, limited to one (1) each every thirty-six (36) months.
  - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for ***dependent*** children through the age of eighteen (18), limited to one (1) treatment per calendar year.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments. This does not include space maintainers used in orthodontics to create a space between teeth.
6. Topical application of sealant to permanent posterior teeth, for ***dependent*** children through the age of fourteen (14), limited to one (1) treatment per tooth every three (3) consecutive years.

### *Class II Basic Dental Services*

1. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.
2. **Tests and Laboratory Examinations.** Benefits are provided for the following tests and laboratory examinations related to covered dental treatment. Routine or preventive tests are not covered. Sometimes, a service could be considered an integral part of another service or case fee procedure. In such cases, benefits will be limited to the allowance for the major service or procedure. Separate benefits will not be available if billed separately from the major procedure.

- a. Bacteriologic studies for determination of pathologic agents
  - b. Caries susceptibility tests
  - c. Pulp vitality tests
  - d. Diagnostic photographs
  - e. Histopathologic examinations
3. **Basic Restorative Services.** The following services are covered for restoration of tooth damage due to dental decay or injury only. Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic reasons are not covered. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Separate charges for these inclusive services are not covered. Multiple surfaces restored on the same tooth are considered one filling. The Plan allowance will be based on the number of surfaces for each filling per each tooth.
- a. Fillings consisting of resin (silver amalgam, silicate and plastic or a composite of these materials).
  - b. Sedative filling when not considered part of another procedure. Example: root canal therapy, palliative care.
  - c. Core Buildup, including any pins, pin retention, cast post and core in addition to crown.
  - d. Pin Retention in addition to restoration.
  - e. Temporary Crown for fractured tooth.
4. **Endodontics.** Coverage includes treatment for diseases of pulp cavities inside the root of a tooth and surrounding tissues. Allowance for endodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive services are not covered.
- a. Pulp capping exclusive of final restoration.
  - b. Therapeutic pulpotomy exclusive of final restoration. Not covered separately if done during root canal therapy.
  - c. Root canal therapy including treatment plan, intraoperative X-rays, clinical procedures and follow up care.
  - d. Periapical services including apicoectomy, retrograde filling per root, root amputation per root and reimplantation of tooth including necessary splinting.
  - e. Hemisection (including any root removal), not including root canal therapy.
- Bleaching of a discolored tooth is not covered whatever the reason.
5. **Periodontics.** Coverage includes treatment of periodontal and other diseases to or around the root portion of a tooth except periodontal prophylaxis. Allowance for periodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive procedures are not covered.
- a. Surgical periodontic preoperative examination.
  - b. Gingival curettage when not part of tooth extraction. (Generally needed for localized sites of recalcitrant periodontitis, juvenile periodontitis, treatment of gingivitis, slight periodontitis or aesthetic purposes.) Benefits are not payable for services rendered primarily for aesthetic purposes.
  - c. Mucogingival surgery.
6. **Oral Surgery.** Allowance for oral surgery includes supplies, local anesthesia and normal follow-up care. Separate charges for these inclusive services are not covered. Surgery must be due to oral or dental disease or injury. Services done for aesthetic or cosmetic purposes are not covered. Services done for orthodontic reasons are covered as orthodontic expense subject to the orthodontic benefit limitations.
- a. Simple extractions.
  - b. Root removal of exposed roots when not related to extraction of teeth.
  - c. Surgical extractions of erupted teeth.
  - d. Surgical extraction of bony or tissue impacted teeth (partially or completely impacted).
  - e. Surgical removal of residual tooth roots (cutting procedure) when not related to tooth extraction.
  - f. Biopsy of oral tissue done by incisional cutting procedure. Biopsy not covered if done with another cutting procedure.

- g. Surgical treatment of tumor, cysts and soft tissue abscess when not related to another oral procedure.
  - h. Treatment of fractures including reduction with or without tooth immobilization and surgical approaches of the mandible, maxilla, malar and/or zygomatic arch, alveolus, (stabilization of teeth, open reduction splinting) and facial bones (complicated reduction with fixation and multiple surgical approaches).
  - i. Injection of antibiotics by the dentist or physician.
7. **Repairs Crowns and Dentures.** Repairs, relining, recement or adjustments of crowns, inlays, dentures and bridgework are covered. Benefits will be based on the type of dental service needed to make the prosthetic serviceable. Separate charges for repairs, relining, recement and adjustments done within six months of placement are not covered.
  8. **General Anesthesia.** The administration of general anesthetic is covered only when dentally or medically necessary in conjunction with covered oral or dental surgery or for other covered dental procedures. The anesthetic agent must produce a state of unconsciousness with absence of pain sensation over the whole body. Benefits will not be paid for general anesthesia that does not meet the preceding requirement, whatever the reason.
  9. **Prescription Drugs** when ordered by a physician in connection with covered dental procedures. Drugs must be considered medically or dentally necessary and require a physician's prescription.

*Class III Major Dental Services*

1. **Major Fillings and Crowns.** The following services are covered for restoration of tooth damage due to illness or injury only:
  - a. Gold or other high noble metallic fillings.
  - b. Inlay or onlays restorations consisting of metallic, porcelain/ceramic or composite/resin when not part of a bridge.
  - c. Crown restorations consisting of resin, porcelain/ceramic or with noble metal and full cast or partially cast metal when not part of a bridge.
  - d. Stainless steel crown restorations.
  - e. Core Buildup, including any pins, pin retention, cast post and core, in addition to crown.

Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic purposes are not covered. Any series of treatment that involves crowns on any of the four front upper or lower teeth will automatically be considered cosmetic, unless a pretreatment review shows that a deterioration of each tooth makes other restoration methods inapplicable. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Additional benefits will not be payable for any charges billed for the inclusive services.

**NOTE:** The charge for a crown, inlay or for a gold or other high noble metallic filling will be limited to the charge for a silver, porcelain, resin or composite filling unless the tooth cannot be adequately restored by such fillings. Replacement of a crown or gold filling is covered only if the crown or filling is over five years old.

2. **Prosthodontics (prosthetics, dentures and bridgework).** Allowance for prosthetic procedures. includes preparation, materials or supplies. Allowance also includes rebase, reline, recement or adjustments within six (6) months after the date of placement and other usual follow-up care. Separate charges for inclusive services will not be paid.

- a. **Initial or First Placement.** Coverage is available for the initial placement of a denture or bridge when needed to replace one or more diseased or injured natural teeth that were extracted or lost while covered under the Plan. The denture or the bridgework must replace the missing tooth or teeth and be installed within 12 months after the date the tooth or teeth were lost or extracted. An initial placement denture or bridgework is considered an initial prosthetic when it does not replace an existing denture or bridgework. If fixed bridge is used, the abutments (crowns) will be covered only to the extent that they are needed to support the pontics that replaces the missing natural tooth.
- b. **Replacement or Addition of Teeth for Existing Dentures or Bridgework.** Allowance for prosthetic procedures includes preparation and supplies. Allowance also includes rebase, relin, recement, adjustments within six months after placement and other usual follow-up care. Separate charges for inclusive services will not be paid. Replacement of dentures or bridgework or tooth additions to existing prosthetics are covered for:
  - 1) Additional loss or extraction of diseased or injured natural teeth while covered under this Plan; or
  - 2) The existing denture or bridgework has been in use at least five years and cannot be made serviceable and the person has been covered under the Plan for two or more years; or
  - 3) The existing denture is an immediate temporary denture installed within the past twelve months and must now be replaced by a permanent denture; or
  - 4) The existing denture is no longer serviceable due to an accidental injury requiring oral surgery or oral surgery which involves changing the position of muscle attachments, removing a tumor, cyst, torus or excess tissue.

Replacements for any other reasons are not covered. Under no circumstances will the Plan pay replacement of dentures or **bridgework** that can be made serviceable.

- c. **Temporary or Interim Prosthodontics.** Temporary or interim bridgework is considered part of the total service for dentures or bridgework. Separate benefits will not be payable for this service.
3. **Temporomandibular Joint Dysfunction (TMJ).** Coverage is available for treatment of TMJ. However, this benefit excludes expenses related to TMJ surgery.
4. **Dental surgical implants and related services.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

*Class IV Orthodontic Services*

1. Any dental expense furnished in connection with the orthodontic treatment.
  2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care.
  3. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
  4. Comprehensive full-banded and bracketed orthodontic treatment.
  5. Fixed or cemented appliance to control harmful habits.
1. **Coverage Limitations.** Coverage is limited to orthodontic services for treatment of handicapping malocclusion (usually four or more degree arch discrepancy). Benefits will not be payable for any orthodontic service which is primarily cosmetic or aesthetic.

Covered services must be incurred while the individual was enrolled in the Plan. For example, if the appliance was inserted before the effective date of coverage, benefits would not be payable for the appliance. However, coverage would be available for orthodontic adjustments incurred while eligible under the Plan.

2. **Benefit Payments/Course of Orthodontic Treatment.** Benefits will be payable on a report basis. The dentist must complete a dental form with full details of the treatment plan. The completed form must be mailed to the *claims processor* for benefit approval. Plan Payment will be prorated based on the available benefits for the course of treatment. Two or more course of treatments will be considered one course of orthodontic treatment, unless separated by at least two (2) years from the date of last orthodontic treatment.

If orthodontic services are ended for any reason before the completion of the treatment course, benefits will cease at the time care ended. If the patient becomes ineligible for coverage under the Plan, benefits will not be paid for any period after the date coverage ends. If the patient is on a quarterly payment schedule, payment will only be based on that portion of the quarterly period that the patient actually received services and was eligible for Plan benefits. Charges for the replacement and/or repair of any appliance furnished under the treatment plan are not covered. Separate benefits will not be payable.

After initial benefit payment, benefits will be paid in quarterly portions (every three months) during the remainder of the treatment course. Benefits are available only for services that are incurred while the participant is covered under the Plan.	
<b>Initial Diagnosis, Evaluation, pre-care and appliances.</b>	Initial Plan Payment will be 15% of the total benefit allowance for the course of treatment.
<b>Monthly Treatment</b>	A monthly benefit for each month, payable at the end of each three month period during the remainder of the orthodontic treatment course will be determined by dividing 45% of the total benefit allowance for the course of treatment by the total number of months needed to complete the treatment course.

## ***DENTAL EXCLUSIONS***

In addition to the *Plan Exclusions*, no benefit will be provided under the *Plan* for dental expenses *incurred* by a *covered person* for the following:

1. Charges for any device ordered while the individual was covered under the *Plan* and not delivered or installed within thirty (30) days after termination of coverage.
2. Transplant or reimplantation of any type including any prosthetic device attached to it. This exclusion includes reimplantation of natural tooth or teeth that has been dislodged or removed.
3. Any procedure not listed under *Covered Dental Expenses*.
4. Any procedure which began before the date the *covered person's* dental coverage started, to include a service which is:
  - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
  - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
  - c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

X-rays and prophylaxis shall not be deemed to start a dental procedure.
5. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.

6. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.
7. A service not furnished by a dentist, except:
  - a. Services performed by a licensed dental hygienist under a *dentist's* supervision;
  - b. X-rays ordered by a *dentist*; and
  - c. Denturist.
8. Charges for over-dentures, including related root canal therapy and supportive restorations.
9. Replacement of a prosthetic which in the *dentist's* opinion can be repaired or does not need replacement.
10. Fixed prosthetics and/or partials. An allowance will be made for a temporary acrylic partial.
11. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
12. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
13. Charges resulting from changing from one *dentist* to another while receiving treatment, or resulting from receiving care from more than one *dentist* for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one *dentist* had performed all the required dental services.
14. Charges for porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children. An allowance will be made for an acrylic crown.
15. Charges for precision attachments, semi-precision attachments.
16. Charges for instruction in dental plaque control, dental hygiene, or nutritional counseling.  
Charges for adjustments of new dentures within six (6) months of installation.  
Charges for infection control (OSHA fees).  
Charges for local anesthetic or analgesia including gas (nitrous oxide).
17. Charges for behavior management.
18. Dental services related to procedures that do not meet common dental standards or are related to investigative or experimental procedures or to methods not approved by the appropriate dental specialty society.
19. Dental services that are not dentally or medically necessary for the treatment of dental illness or injury. Services not prescribed as necessary by a dentist or physician.
20. Preventive care except as otherwise specifically included in the Plan.
21. Replacement or duplication of a bridge, crown or denture for one or more of the following:
  - a. Made useless due to patient abuse, misuse or neglect.
  - b. Lost or stolen appliance.
  - c. Within five years of an initial installation or a prior replacement except as otherwise specifically included in the Plan.
  - d. Which is or can be made functional or serviceable according to common dental standards.
 Athletic appliances, mouth guards and other protective appliances.
22. Sedation or separate charges for local anesthetic. General anesthesia except as otherwise specifically included in the Plan.
23. Drugs and Medicines obtainable without a prescription or not connected with a covered dental procedure.
24. Charges more than the usual, customary, and reasonable allowance for covered services or supplies. Charges more than the allowable fee for a standard procedure or for alternate treatment covered instead of non-standard or specialized dental care.

25. Services or supplies received from a dental or medical department sponsored or maintained by, an employer, labor union or other similar person or group.
26. Services or supplies received from a hospital.
27. Services rendered by an immediate relative or household member.
28. Services or supplies to the extent that the care or payment of the care is unlawful where the patient resides or where the care was received at the time rendered.
29. Services or supplies covered under a medical plan sponsored by the District. The coordination of benefits provision does not apply in this case.
30. Services or supplies for which benefits are or can be provided because of related illness or injury arising from the past or present service of any person in the armed forces of a government.
31. Services or supplies related to an occupational injury or occupational sickness that entitles the Covered Person to benefits under a worker's compensation law or occupational disease law or similar legislation. Payment will not be made even if you do not claim the entitled benefit.
32. Services or supplies that could be provided by or paid for by any governmental program (other than Medicaid) under which you could be covered. Exception: services or supplies covered by Medicare.
33. Services or supplies received for which no charge would have been made without coverage under the Plan or for which there is no obligation to pay.
34. Services or supplies received because of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace.
35. Service rendered for medical/dental summaries and invoice preparations or fees for completion of claim forms or fees for missed appointments, telephone consultations and fees for services not actually provided.
36. Services or supplies that are not included as covered services under the Plan or that are not rendered and billed by a qualified provider.

# ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the *Plan's* requirements for a person to participate in the *Plan*.

## ***EMPLOYEE ELIGIBILITY***

All *full-time* or *part-time employees* regularly scheduled to work at least thirty (30) hours per work week shall be eligible to enroll for coverage under the *Plan*. This does not include temporary or seasonal *employees*.

If applicable under the *Affordable Care Act*, an *employee* of the *employer* who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the *employer's measurement period* and is eligible during the *employer's stability period*, as documented by the *employer* and consistent with the *Affordable Care Act*, applicable regulations and regulatory guidance, is eligible to enroll under the *Plan*, provided the *employee* is a member of a class eligible for coverage and has satisfied any waiting period that may be required by the *employer*.

## ***EMPLOYEE ENROLLMENT***

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for himself within thirty (30) days of becoming eligible for coverage. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

## ***RETIREE ENROLLMENT***

A *retiree* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for himself within thirty (30) days of retirement. The *retiree* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

If you declined enrollment for yourself and/or your spouse, you may not re-enroll at a later date.

## ***EMPLOYEE(S) EFFECTIVE DATE***

Eligible *employees*, as described in *Employee Eligibility*, are covered under the *Plan* as follows –

- If a person is hired the first of the month and submits all required paperwork by the first of the month, they can be effective for the 1<sup>st</sup> of the month.
- If hired after the 1<sup>st</sup> of the month and after all paperwork is received, the employee's effective date is the 1<sup>st</sup> of the following month.

## ***RETIREE EFFECTIVE DATE***

Eligible *retirees*, as described in *Retiree Eligibility*, are covered under the *Plan* on the date of retirement

## ***DEPENDENT(S) ELIGIBILITY***

The following describes *dependent* eligibility requirements. The *employer* will require proof of *dependent* status.

1. The term "spouse" means the spouse of the *employee/retiree* under a legally valid existing marriage, as defined by the state in which the *employee/retiree* was legally married, unless court ordered separation exists.

The term "domestic partner" means that the person recognized as an unmarried **employee's/retiree's** same gender partner with whom the **employee/retiree** has a committed long term relationship that fully meets the conditions for Domestic Partner eligibility shown below. Same-sex Domestic Partners must be married or live in a state where same-sex couples are not permitted to marry in order to be eligible for coverage.

Domestic Partners will be considered for Plan enrollment on the same basis as a Spouse. Domestic Partners are defined as two same sex individuals who share a household and who have a relationship of financial independence and mutual care.

The following are required for eligibility in the Bedford Central School District Health Plan:

- a. Partners must be the same sex; and
- b. Partners must be of legal age to marry in New York State; and
- c. Partners must not be related by blood to a degree of closeness which would prohibit marriage in New York State; and
- d. Partners must have resided together for at least 12 months and intend to do so indefinitely; and
- e. Partners must sign the Affidavit of Domestic Partnership; and
- f. Partners who reside in New York City must register with the City Domestic Partnership Registry and provide the District Benefits Office with the Certification of Domestic Partnership; and
- g. Partners must otherwise meet the requirements and limitations of eligibility that pertain to all **employees/retirees** of the Bedford Central School District:
  1. Joint ownership of property (i.e. real estate), or a joint mortgage or joint lease that is at least twelve (12) months duration.
  2. Partners have been listed on each other's will for at least twelve months.
  3. Partners have been a beneficiary of the Employee's ERS or TRS retirement plan for at least twelve (12) months.
  4. Partners hold general power of attorney or health care power of attorney for each other.
  5. Domestic Partnership agreement that creates a personal and financial interdependence including joint and several liability for each other's debts and expenses and responsibility for mutual care.

The District will require documentation of criteria shown above. An Affidavit of Domestic Partnership signed by both partners must be provided to the District Benefits Office. Affidavit forms are available from the District Benefits office.

Eligibility ends when the Domestic Partnership no longer meets the above criteria. If criteria are no longer met, the District Benefits Office must be notified, in writing, within 30 days.

2. The *employee's* natural child, stepchild, your domestic partner's child, legally adopted child, child *placed for adoption* a foster child, through the end of the month in which the child reaches twenty-six (26) years of age.
3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the *Plan*. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage only if the *employee* is also covered under the *Plan*. An application for enrollment must be submitted to the *employer* for coverage under the *Plan*. The *employer/plan administrator* shall establish written procedures for determining whether a medical child support order is a NMSN and for administering the provision of benefits under the *Plan* pursuant to a valid NMSN. Within a reasonable period after receipt of a medical child support order, the *employer/plan administrator* shall determine whether such order is a NMSN, as defined in 42 U.S.C. § 666 of the Child Support Performance and Incentive Act of 1998.  
  
The *employer/plan administrator* reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.
4. A *dependent* child who was covered under the *Plan* prior to the end of the month in which the child reached twenty-six (26) years of age and who lives with the *employee*, is unmarried, incapable of self-sustaining employment and dependent upon the *employee* for support due to a mental and/or physical disability, will remain eligible for coverage under the *Plan* beyond the date coverage would otherwise terminate.

Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the *employer* or *claims processor*, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:

- a. Cessation of the mental and/or physical disability;
- b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *employee* may enroll eligible *dependents*. However, if both the husband and wife are *employees*, they may choose to have one covered as the *employee*, and the spouse covered as the *dependent* of the *employee*, or they may choose to have both covered as *employees*. Eligible children may be enrolled as *dependents* of one spouse, but not both.

## ***DEPENDENT ENROLLMENT***

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for his eligible *dependents* within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

## ***DEPENDENT(S) EFFECTIVE DATE***

Eligible *dependent(s)*, as described in *Dependent(s) Eligibility*, will become covered under the *Plan* on the later of the dates listed below, provided the *employee* has enrolled them in the *Plan* within thirty (30) days of meeting the *Plan's* eligibility requirements and any required contributions are made.

1. The date the *employee's* coverage becomes effective.
2. The date the *dependent* is acquired, provided the *employee* has applied for *dependent* coverage within thirty (30) days of the date acquired.
3. Newborn children shall be covered from birth, provided the *employee* has applied for *dependent* coverage within thirty (30) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is *placed for adoption*, provided the *employee* has applied for *dependent* coverage within thirty (30) days of the date the child is *placed for adoption*.

### ***SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)***

An *employee* or *dependent* who did not enroll for coverage under this *Plan* because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this *Plan*, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of employer contributions toward the other coverage.
3. Legal separation or divorce.
4. Termination of other employment or reduction in number of hours of other employment.
5. Death of *dependent* or spouse.
6. Cessation of other coverage because *employee* or *dependent* no longer resides or works in the service area and no other benefit package is available to the individual.
7. Cessation of *dependent* status under other coverage and *dependent* is otherwise eligible under *employee's Plan*.
8. An incurred claim that would exceed the other coverage's maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

Notwithstanding any provision of the *Plan* to the contrary, all benefits received by an individual under any benefit option, package or coverage under the *Plan* shall be applied toward the applicable *maximum benefit* paid by the *Plan* for any one *covered person* for such option, package or coverage under the *Plan*, and also toward the *maximum benefit* under any other options, packages or coverages under the *Plan* in which the individual may participate in the future.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The *employee* or *dependent* must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The *effective date* of coverage as the result of a special enrollment shall be the date of loss of other coverage.

## ***SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)***

An **employee** who is currently covered or not covered under the **Plan**, but who acquires a new **dependent** may request a special enrollment period for himself, if applicable, his newly acquired **dependent** and his spouse, if not already covered under the **Plan** and otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new **dependent** includes:

- marriage
- birth of a **dependent** child
- adoption or **placement for adoption** of a **dependent** child

The **employee** must request the special enrollment within thirty (30) days of the acquisition of the **dependent**.

The **effective date** of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;
2. in the case of a **dependent's** birth, the date of such birth;
3. in the case of adoption or **placement for adoption**, the date of such adoption or **placement for adoption**.

## ***SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)***

The **Plan** intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An **employee** who is currently covered or not covered under the **Plan** may request a special enrollment period for himself, if applicable, and his **dependent**. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The **employee** or **dependent** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

## ***OPEN ENROLLMENT***

Open enrollment is the period designated by the **employer** during which the **employee** may change benefit plans or enroll in the **Plan** if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year.

During this open enrollment period, an **employee** and his **dependents** who are covered under the **Plan** or covered under any **employer** sponsored health plan may elect coverage or change coverage under the **Plan** for himself and his eligible **dependents**. An **employee** must make written application (or electronic, if applicable) as provided by the **employer** during the open enrollment period to change benefit plans.

The **effective date** of coverage as the result of an open enrollment period will be the start of the following plan year.

Except for a status change listed below, the open enrollment period is the only time an **employee** may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
  - a. Change in **employee's** legal marital status;
  - b. Change in number of **dependents**;
  - c. Termination or commencement of employment by the **employee**, spouse or **dependent**;
  - d. Change in work schedule;
  - e. **Dependent** satisfies (or ceases to satisfy) **dependent** eligibility requirements;
  - f. Change in residence or worksite of **employee**, spouse or **dependent**.
2. Significant change in the cost of coverage under the **employer's** group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a **leave of absence** under the Family and Medical Leave Act of 1993.
5. Significant change in the health coverage of the **employee** or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
7. A court order, judgment or decree.
8. Entitlement to **Medicare** or Medicaid, or enrollment in a state child health insurance program (CHIP).
9. A COBRA qualifying event.

**NOTE:** Open enrollment does not apply to retirees. If you declined enrollment for yourself and/or your dependents, you may not re-enroll at a later date.

## ***ENROLLMENT CHANGES***

Except for a status change listed below, a Special Enrollment Period is the only time an **employee** may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
  - a. Change in **employee's** legal marital status;
  - b. Change in number of **dependents**;
  - c. Termination or commencement of employment by the **employee**, spouse or **dependent**;
  - d. Change in work schedule;
  - e. **Dependent** satisfies (or ceases to satisfy) **dependent** eligibility requirements;
  - f. Change in residence or worksite of **employee**, spouse or **dependent**.
2. Significant change in the cost of coverage under the **employer's** group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a **leave of absence** under the Family and Medical Leave Act of 1993.
5. Significant change in the health coverage of the **employee** or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
7. A court order, judgment or decree.
8. Entitlement to **Medicare** or Medicaid, or enrollment in a state child health insurance program (CHIP).
9. A COBRA qualifying event.

# TERMINATION OF COVERAGE

Except as provided in the *Plan's Continuation of Coverage* (COBRA) or any *Extension of Benefits* provision, coverage will terminate on the earliest of the following dates:

## ***TERMINATION OF EMPLOYEE/RETIREE COVERAGE***

1. The date the *employer* terminates the *Plan* and offers no other group health plan.
2. The last day of the month in which the *employee* ceases to meet the eligibility requirements of the *Plan*.
3. The last day of the month in which employment terminates, as defined by the *employer's* personnel policies.
4. The date the *employee* becomes a full-time, active member of the armed forces of any country.
5. The date the *employee/retiree* ceases to make any required contributions.

## ***TERMINATION OF DEPENDENT(S) COVERAGE***

1. The date the *employer* terminates the *Plan* and offers no other group health plan.
2. The date the *employee's* coverage terminates.
3. The date such person ceases to meet the eligibility requirements of the *Plan*, except that for a *dependent* child, termination shall be the last day of the month in which the *dependent* child reaches age twenty-six (26).
4. The date the *employee* ceases to make any required contributions on the *dependent's* behalf.

## ***LEAVE OF ABSENCE***

Coverage may be continued for a limited time, contingent upon payment of any required contributions for *employees* and/or *dependents*, when the *employee* is on an authorized *leave of absence* from the *employer*.

## ***LAYOFF***

Coverage may be continued for a limited time, contingent upon payment of any required contributions for *employees* and/or *dependents*, when the *employee* is subject to an *employer layoff*.

## ***SEVERANCE***

Coverage may be continued for a limited time, contingent upon payment of any required contributions for *employees* and/or *dependents*, as the result of a severance package agreement for the length of time negotiated between the *employee* and *employer*. Such coverage shall run concurrently with any available COBRA continuation coverage. In no event will coverage continue for more than eighteen (18) months after the *employee's* active service ends.

## ***DEATH***

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

- a. **All Members Prior to July 1, 2006.** If an Active Employee or Retiree dies, his or her survivor Dependents who are enrolled in his or her family coverage will continue to be eligible for coverage at no cost for the three (3) months following the Employee or Retirees' death. After three (3) months, this extension of eligibility continues to apply to survivors of eligible Retirees or survivors of eligible Employees **who have completed at least ten (10) years of active service with the District.** To be covered, the survivors must request enrollment within ninety (90) days after the death of the Employee or Retiree. **If enrollment is not made within ninety (90) days, eligibility under this rule is not available.** The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan. This coverage ends for the Spouse/Domestic Partner when he or she marries/remarries/or forms a Domestic Partnership. For survivor children, coverage ends when they otherwise no longer meet the definition of Dependent Children. For example, reach limiting age or no longer a student. If survivors are not eligible for this extension, do not choose this extension or if coverage ends under this rule, they could be eligible for "Continuation of Coverage" shown later in this document.
- b. **July 1, 2006 and after for Active Employees only of the Bedford Teachers Association (BTA) and Bedford Association of School Administrators (BASA), and July 1, 2007 and after for Active Employees only of the Civil Service Employees Association (CSEA).** If an Active Employee dies, his or her survivor Dependents who are enrolled in his or her family coverage will continue to be eligible for coverage at no cost to the surviving Spouse/Domestic Partner and or survivor Dependents for the time specified below:
  1. **Active Employees who have completed over 10 years of employment with the District,** coverage will be provided at no cost for the three (3) years following the Active Employee's death. Following completion of the initial Coverage period, the Spouse/Domestic Partner or eligible Dependents of the Active Employee may elect to continue to participate in the Districts' Health Care Plan. The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan.
  2. **Active Employees who have worked for the District 10 years or less,** coverage will be provided at no cost for the two (2) years following the Active Employee's death. Following completion of the initial coverage period, the Spouse/Domestic Partner or eligible Dependents of the Active Employee may elect to continue to participate in the Districts' Health Care Plan. The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan.

Enrollment for survivor benefits is not automatic. To be covered, the survivors must request enrollment within 90 days after the death of the Active Employee. **If enrollment is not made within ninety (90) days, eligibility under this rule is not available.** This coverage ends for the Spouse/Domestic Partner when he or she marries/remarries/or forms a Domestic Partnership. For survivor Children, coverage ends when they otherwise no longer meet the definition of Dependent children. For example, reach limiting age or are no longer a student. If survivors are not eligible for this extension or if coverage ends under this rule, they could be eligible for "Continuation of Coverage" shown later in this document.

## ***FAMILY AND MEDICAL LEAVE ACT (FMLA)***

### ***Eligible Leave***

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993 (FMLA), as amended, has the right to continue coverage under the ***Plan*** for up to twelve (12) weeks, or (twenty-six (26) weeks in certain circumstances). ***Employees*** should contact the ***employer*** to determine whether they are eligible under FMLA.

### ***Contributions***

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan***. The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

### ***Reinstatement***

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

### ***Repayment Requirement***

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

## ***EMPLOYEE REINSTATEMENT***

An ***employee*** who returns to work following an approved ***leave of absence, layoff***, or termination of employment will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

# CONTINUATION OF COVERAGE

In order to comply with federal regulations, the *Plan* includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits.

## ***QUALIFYING EVENTS***

Qualifying events are any one of the following events that would cause a *covered person* to lose coverage under the *Plan* or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the *employee/retiree*.
2. The *employee's* termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the *Plan*. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce or legal separation from the *employee/retiree*.
4. The *employee's/retiree's* entitlement to *Medicare* benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this *Plan*.
5. A *dependent* child no longer meets the eligibility requirements of the *Plan*.
6. A covered *retiree* and their covered *dependents* whose benefits were substantially eliminated within one (1) year of the *employer* filing for Chapter 11 bankruptcy.

## ***NOTIFICATION REQUIREMENTS***

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered *employee/retiree*, or a child's loss of *dependent* status, the *employee/retiree* or *dependent* must submit a completed Qualifying Event Notification form to the *plan administrator* (or its designee) within sixty (60) days of the latest of:
  - a. The date of the event;
  - b. The date on which coverage under the *Plan* is or would be lost as a result of that event; or
  - c. The date on which the *employee/retiree* or *dependent* is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Qualifying Event Notification form is available from the *plan administrator* (or its designee). In addition, the *employee/retiree* or *dependent* may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the *plan administrator* (or its designee) will notify the *employee/retiree* or *dependent* of his rights to continuation of

coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under the **Plan** other than the ones described in Paragraph 1 above, the **plan administrator** (or its designee) will furnish an Election Notice to the **employee/retiree** or **dependent** not later than forty-four (44) days after the date on which the **employee/retiree** or **dependent** loses coverage under the **Plan** due to the qualifying event.
3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the **plan administrator** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.
4. In the event an Election Notice is furnished, the eligible **employee/retiree** or **dependent** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the **Plan** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the **employee/retiree** or **dependent** chooses to have continuation coverage, he must advise the **plan administrator** (or its designee) of this choice by returning to the **plan administrator** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the **plan administrator** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:
  - a. The date coverage under the **Plan** would otherwise end; or
  - b. The date the person receives the Election Notice from the **plan administrator** (or its designee).
5. Within forty-five (45) days after the date the person notifies the **plan administrator** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

## ***COST OF COVERAGE***

1. The **Plan** requires that **covered persons** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the **plan administrator** (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.
2. For a person originally covered as an **employee/retiree** or as a spouse, the cost of coverage is the amount applicable to an **employee/retiree** if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an **employee/retiree**.

## ***WHEN CONTINUATION COVERAGE BEGINS***

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for **dependents** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the **Plan**.

## ***FAMILY MEMBERS ACQUIRED DURING CONTINUATION***

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

## ***EXTENSION OF CONTINUATION COVERAGE***

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:
  - a. Death of the ***employee/retiree***.
  - b. Divorce or legal separation from the ***employee/retiree***.
  - c. The child's loss of ***dependent*** status.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

- (i.) The date of that event;
- (ii.) The date on which coverage under the ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred; or
- (iii.) The date on which the ***employee/retiree*** or ***dependent*** is furnished with a copy of the Plan Document and Summary Plan Description.

A copy of the Additional Extension Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee/retiree*** during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
  - a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60<sup>th</sup>) day of continuation coverage; and
  - b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the ***plan administrator*** (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

- (i.) The date of the disability determination by the Social Security Administration;

- (ii.) The date of the 18-Month Qualifying Event;
- (iii.) The date on which the person loses (or would lose) coverage under the *Plan* as a result of the 18-Month Qualifying Event; or
- (iv.) The date on which the person is furnished with a copy of the Plan Document and Summary Plan Description.

Should the disabled person fail to notify the *plan administrator* (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The *Plan* may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

- (A.) The date of the final determination by the Social Security Administration; or
- (B.) The date on which the individual is furnished with a copy of the Plan Document and Summary Plan Description.

## **END OF CONTINUATION**

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.
2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.
3. Thirty-six (36) months from the date continuation began for *dependents* whose coverage ended because of the death of the *employee/retiree*, divorce or legal separation from the *employee/retiree*, or the child's loss of *dependent* status.
4. The end of the period for which contributions are paid if the *covered person* fails to make a payment by the date specified by the *plan administrator* (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under the *Plan* or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."
5. The date coverage under the *Plan* ends and the *employer* offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
6. The date the *covered person* first becomes entitled, after the date of the *covered person's* original election of continuation coverage, to *Medicare* benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
7. The date the *covered person* first becomes covered under any other employer's group health plan after the original date of the *covered person's* election of continuation coverage.
8. For the spouse or *dependent* child of a covered *employee* who becomes entitled to *Medicare* prior to the spouse's or *dependent's* election for continuation coverage, thirty-six (36) months from the date the covered *employee* becomes entitled to *Medicare*.
9. 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 US Code with respect to the *employer*, as is the spouse/domestic partner, surviving spouse/domestic partner or dependent child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse/domestic partner, surviving spouse/domestic partner or dependent child was a beneficiary under the *plan*.

## ***SPECIAL RULES REGARDING NOTICES***

1. Any notice required in connection with continuation coverage under the ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee/retiree*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under the ***Plan***, any notice required to be provided by any individual who is either the ***employee/retiree*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee/retiree*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
  - a. A single notice addressed to both the ***employee/retiree*** and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the spouse resides at the same location as the ***employee/retiree***; and
  - b. A single notice addressed to the ***employee/retiree*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee/retiree*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

## ***MILITARY MOBILIZATION***

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and the ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***plan administrator*** (or its designee) may require the ***employee*** and the ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the ***employee*** and the ***employee's dependent*** will be reinstated without a waiting period, regardless of their election of COBRA continuation coverage.

## ***PLAN CONTACT INFORMATION***

Questions concerning the ***Plan***, including any available continuation coverage, can be directed to the ***plan administrator*** (or its designee).

## ***ADDRESS CHANGES***

In order to help ensure the appropriate protection of rights and benefits under the ***Plan***, ***covered persons*** should keep the ***plan administrator*** (or its designee) informed of any changes to their current addresses.

## ***VESTED EMPLOYEE CONTINUATION OF COVERAGE***

The District Benefits Office can provide details concerning established rules and the costs for continuing coverage while in vested status.

**General eligibility rules for vested rights.** *Employees*, who end employment with the District before retirement age, may be eligible to continue coverage both while in vested status and, subsequently, during retirement. To be eligible, the *employee* must have:

1. Satisfied the minimum requirements established by law for vesting his or her retirement allowance; and
2. Met all the minimum requirements except age for Retiree coverage. These requirements must have been met at the time the *employee* terminated employment. They must not be satisfied while the *employee* is in vested status or after the retirement allowance begins.

**Requesting continuation of coverage while in a vested status.** If the *employee* wishes to continue this health Plan while vested, he/she must request continuation of coverage from the District at the time employment is terminated. When the District authorizes continuation of coverage, he/she will be required to pay the designated plan participation costs from the date he/she is terminated. The District Benefits Office will assist with the procedures required to keep coverage in effect.

If coverage ends because the *employee* made no request to continue coverage, or failed to make participating payments during vested continuation coverage, he/she will not be permitted to reinstate coverage either during the remainder of the vested status period or after retirement. Once he/she has established eligibility to continue health Plan coverage as a vestee, that eligibility will not be impaired by subsequent employment.

# CLAIM FILING PROCEDURE

A “pre-service claim” is a claim for a **Plan** benefit that is subject to the prior certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for **Plan** benefits are “post-service claims” and are subject to the rules described in the section, *Post-Service Claim Procedure*.

## POST-SERVICE CLAIM PROCEDURE

### ***FILING A CLAIM***

Claims should be submitted to the address shown on the ID card. The date of receipt will be the date the claim is received by the **claims processor**.

All claims submitted for benefits must contain all of the following:

- a. Name of patient.
- b. Patient’s date of birth.
- c. Name of **employee/retiree**.
- d. Address of **employee/retiree**.
- e. Name of **employer** and group number.
- f. Name, address and tax identification number of provider.
- g. **Employee/retiree** CoreSource Member Identification Number.
- h. Date of service.
- i. Diagnosis and diagnosis code.
- j. Description of service and procedure number.
- k. Charge for service.
- l. The nature of the **accident, injury** or **illness** being treated.

Timely Filing: All claims not submitted within twelve (12) months from the date the services were rendered will be considered not timely file, will not be a **covered expense** and will be denied.

The **covered person** may ask the health care provider to submit the claim directly to the **claims processor** or to the **Preferred Provider Organization** as outlined above, or the **covered person** may submit the bill with a claim form. However, it is ultimately the **covered person’s** responsibility to make sure the claim for benefits has been filed.

### ***NOTICE OF AUTHORIZED REPRESENTATIVE***

The **covered person** may provide the **plan administrator** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to the release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

### ***NOTICE OF CLAIM***

A claim for benefits should be submitted to the **claims processor** within ninety (90) calendar days after the occurrence or commencement of any services by the **Plan**, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than the timely filing limit stated above, unless the claimant is legally incapacitated.

Notice given by or on behalf of a *covered person* or his beneficiary, if any, to the *plan administrator* or to any authorized agent of the *Plan*, with information sufficient to identify the *covered person*, shall be deemed notice of claim.

## ***TIME FRAME FOR BENEFIT DETERMINATION***

After a completed claim has been submitted to the *claims processor*, and no additional information is required, the *claims processor* will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the *Plan's* control.

After a completed claim has been submitted to the *claims processor*, and if additional information is needed for determination of the claim, the *claims processor* will provide the *covered person* (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the *Plan* expects to make a decision. The *covered person* will have forty-five (45) calendar days to provide the information requested, and the *Plan* will complete its determination of the claim within fifteen (15) calendar days of receipt by the *claims processor* of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

## ***NOTICE OF BENEFIT DENIAL***

If the claim for benefits is denied, the *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
  - a. The denial code and its specific meaning, and
  - b. A description of the *Plan's* standards, if any, used when denying the claim.
3. Reference to the *Plan* provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the *Plan's* claim appeal procedure and applicable time limits.
6. A statement that if the *covered person's* appeal (Refer to *Appealing a Denied Post-Service Claim* below) is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *covered person's* medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## ***APPEALING A DENIED POST-SERVICE CLAIM***

The "*named fiduciary*" for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person**, for a full and fair review:

1. The **covered person** has the right to submit documents, information and comments and to present evidence and testimony.
2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
3. Before a final determination on appeal is rendered, the **covered person** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the **Plan** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination. However there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide the **covered person** in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
  - a. The date the **covered person** responds to the new or additional rationale or evidence; or
  - b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the **covered person**.
4. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.
5. The review by the **named fiduciary** will not afford deference to the original denial.
6. The **named fiduciary** will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
  - a. The **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment; and
  - b. The **professional provider** utilized by the **named fiduciary** will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other **professional provider** who was consulted in connection with the original denial.
8. If requested, the **named fiduciary** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

## ***NOTICE OF BENEFIT DETERMINATION ON APPEAL***

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific **Plan** provisions on which the denial is based.
3. A statement that the **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
4. A statement of the **covered person's** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the **covered person's** appeal is denied, the **covered person** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## ***FOREIGN CLAIMS***

In the event a *covered person* incurs a *covered expense* in a foreign country, the *covered person* shall be responsible for providing the following information to the *claims processor* before payment of any benefits due are payable:

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

## PRE-SERVICE CLAIM PROCEDURE

### ***HEALTH CARE MANAGEMENT***

***Health care management*** is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care.

Certification of ***medical necessity*** and appropriateness by the ***Health Care Management Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

### ***FILING A PRE-CERTIFICATION CLAIM***

This pre-certification provision will be waived by the ***Health Care Management Organization*** if the ***covered expense*** is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

All ***inpatient*** admissions and other services requiring pre-certification are to be certified by the ***Health Care Management Organization***. For non-urgent care, the ***covered person*** (or their authorized representative) must call the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services. If the ***Health Care Management Organization*** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For ***urgent care***, the ***covered person*** (or their authorized representative) must call the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the ***covered person*** needs medical care that would be considered as ***urgent care***, then there is no requirement that the ***Plan*** be contacted for prior approval.

***Covered persons shall contact the Health Care Management Organization by calling the number shown on their ID card.***

When a ***covered person*** (or authorized representative) calls the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Employee/retiree's*** name, address, phone number and CoreSource Member Identification Number.
2. ***Employer's*** name.
3. If not the ***employee/retiree***, the patient's name, address, phone number.
4. Admitting ***physician's*** name and phone number.
5. Name of ***facility***.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

*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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

However, **hospital** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the **covered person** (or authorized representative) fails to contact the **Health Care Management Organization** prior to services and within the timelines detailed above, the amount of benefits payable for **covered expenses incurred** may be reduced. If the **Health Care Management Organization** declines to grant the full pre-certification requested, benefits for days not certified as **medically necessary** by the **Health Care Management Organization** shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

## **NOTICE OF AUTHORIZED REPRESENTATIVE**

The **covered person** may provide the **plan administrator** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the **covered person** may be processed without a written authorization if the request or claim appears to the **plan administrator** (or its designee) to come from a reasonably appropriate and reliable source (e.g., **physician's** office, individuals identifying themselves as immediate relatives, etc.).

## **TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION**

1. In the event the **Plan** receives from the **covered person** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the **covered person**, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the **covered person** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.
2. After a completed pre-certification request for non-urgent care has been submitted to the **Plan**, and if no additional information is required, the **Plan** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.
3. After a pre-certification request for non-urgent care has been submitted to the **Plan**, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the **Plan**, the **Plan** will, within fifteen (15) calendar days from receipt of the request, provide the **covered person** (or authorized representative) with a notice detailing the circumstances and the date by which the **Plan** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The **covered person** will have forty-five (45) calendar days to provide the information requested, and the **Plan** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the **Plan** of the requested information. Failure to respond in a timely and complete manner will result in a denial.

## **CONCURRENT CARE CLAIMS**

If an extension beyond the original certification is required, the **covered person** (or authorized representative) shall call the **Health Care Management Organization** for continuation of certification.

If a **covered person** (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

- a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
- b. The **inpatient** admission or ongoing course of treatment involves **urgent care**, and
  - (i.) The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the **covered person** (or authorized

- representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or
- (ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the **covered person** (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or
  - (iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the **covered person** (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The **covered person** (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the **covered person** (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the **Health Care Management Organization** determines that the **hospital** stay or course of treatment should be decreased or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the **Health Care Management Organization** shall:

1. Notify the **covered person** of the proposed change, and
2. Allow the **covered person** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the **Health Care Management Organization** determines that continued **confinement** is no longer **medically necessary**, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

## ***NOTICE OF PRE-SERVICE CLAIM DENIAL***

If a pre-certification request is denied in whole or in part, the **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above.

The Notice of Pre-Service Claim Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
  - a. The denial code and its specific meaning, and
  - b. A description of the **Plan's** standards, if any, used when denying the claim.
3. Reference to the **Plan** provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the **Plan's** claim appeal procedure and applicable time limits.
6. A statement that if the **covered person's** appeal (Refer to *Appealing a Denied Pre-Service Claim* below) is denied, the **covered person** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on **medical necessity**, **experimental/investigational** treatment or similar exclusion or limit, the **plan administrator** (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the **covered person's** medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.



## ***APPEALING A DENIED PRE-SERVICE CLAIM***

The “***named fiduciary***” for purposes of an appeal of a denied Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person*** (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
  - a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
  - b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***named fiduciary*** will not afford deference to the original denial.
6. The ***named fiduciary*** will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
  - a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
  - b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

**2nd Appeal Level.** If a ***covered person*** is not satisfied with the decision made on his or her 1st appeal level, a 2nd appeal level appeal may be made directly to the Bedford Claims Appeal Committee (Committee). This Committee is composed of two appointees of the Superintendent of Schools and, according to which unit the appeal or complaint is in, either the president of the Civil Service Employees Association and one appointee of the President of the Civil Service Employees Association; or the President of the Bedford Teacher’s Association and one appointee of the Bedford Teacher’s Association; or the president of the Bedford Association of School Administrators and one appointee of the Bedford Association of School Administrators.

The 2nd appeal level appeal must be in writing and sent to the *plan administrator* within 30 days after receipt of the full or partial denial of benefits based on the 1st level appeal claim appeal decision. The Committee may, in its sole discretion, accept the appeal after such time has elapsed if, in their opinion, extenuating circumstances prevented the participant from making a claim during such period. If necessary, the *plan administrator* will delete or remove the Employee, Retiree and/or Dependent's name before they refer the appeal document to the Committee. Throughout the claims appeal process, confidentiality will be maintained. The Committee will complete its review of the claim appeal within 20 days after its receipt of the appeal documents. The determination of the Committee will be final and binding on all parties, unless the Committee fails to reach a majority decision.

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

**Important:** External appeals must be filed within four (4) months from the date upon which you receive written notification from the Plan that the 1st Appeal Level has upheld the denial regardless of whether you choose to file a 2nd Appeal Level appeal as shown above. By deciding to file a 2nd Appeal Level appeal you are not waiving your option to file an External Appeal, however, in doing so you may miss the four (4) month External Appeal filing deadline.

## ***NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to *urgent care* claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting such a review.
5. A statement that if the *covered person's* appeal is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## **CASE MANAGEMENT**

In cases where the *covered person's* condition is expected to be or is of a serious nature, the **Health Care Management Organization** may arrange for review and/or case management services from a professional qualified to perform such services. The *plan administrator* shall have the right to alter or waive the normal provisions of the **Plan** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the **Health Care Management Organization** may recommend (or change) alternative:

- methods of medical care or treatment;
- equipment; or
- supplies;

that differ from the medical care or treatment, equipment or supplies that are considered *covered expenses* under the **Plan**.

The recommended alternatives will be considered as *covered expenses* under the **Plan** provided the expenses can be shown to be viable, *medically necessary*, and are included in a written case management report or treatment plan proposed by the **Health Care Management Organization**.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that *covered person* or any other *covered person*.

## **POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE**

### ***EXTERNAL APPEAL***

A *covered person*, or the *covered person's* authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the *named fiduciary* within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. *Medical necessity*;
2. Appropriateness;
3. *Experimental* or *investigational* treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a *covered expense*.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1<sup>st</sup> falls on a Saturday, Sunday or Federal holiday.*}

## ***RIGHT TO EXTERNAL APPEAL***

Within five (5) business days of receipt of the request, the *claims processor* will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this *Plan*.

## ***NOTICE OF RIGHT TO EXTERNAL APPEAL***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the *covered person* to perfect the external review request by the later of the following:
  - a. The four (4) month filing period; or
  - b. Within the forty-eight (48) hour time period following the *covered person's* receipt of notification.

## ***INDEPENDENT REVIEW ORGANIZATION***

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the *covered person* in writing of the request's eligibility and acceptance for external review.

## ***NOTICE OF EXTERNAL REVIEW DETERMINATION***

The assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the *covered person*, the *Plan* and *claims processor*, except to the extent that other remedies may be available under State or Federal law.

## ***EXPEDITED EXTERNAL REVIEW***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) the right to request an expedited external review upon the *covered person's* receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the *covered person* or the *covered person's* ability to regain maximum function and the *covered person* has filed an internal appeal request.

2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the **covered person** or the **covered person's** ability to regain maximum function or if the final denial involves any of the following:
  - a. An admission,
  - b. Availability of care,
  - c. Continued stay, or
  - d. A health care item or service for which the **covered person** received **emergency services**, but has not yet been discharged from a **facility**.

Immediately upon receipt of the request for *Expedited External Review*, the **Plan** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
2. Send notice of the **Plan's** decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the **Plan** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the **covered person's** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the **plan administrator** (or its designee) and the **covered person** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

# COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the **covered person** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this **Plan** will be charged against the **Essential Health Benefits/non-Essential Health Benefits maximum benefit**.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

## **DEFINITIONS APPLICABLE TO THIS PROVISION**

"Allowable Expenses" means any reasonable, necessary, and customary expenses **incurred** while covered under this **Plan**, part or all of which would be covered under this **Plan**. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this **Plan**.

When this **Plan** is secondary, "Allowable Expense" will include any deductible or **coinsurance** amounts not paid by the Other Plan(s).

This **Plan** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this **Plan** shall be secondary only.

When this **Plan** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the **covered person** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, **Medicare**, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for **covered persons** in a group, whether on an insured or uninsured basis, including, but not limited to, **hospital** indemnity benefits and **hospital** reimbursement-type plans;
2. **Hospital** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This *Plan*" shall mean that portion of the *employer's Plan* which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the *covered person* for whom a claim is made has been covered under this *Plan*.

## ***EFFECT ON BENEFITS***

This provision shall apply in determining the benefits for a *covered person* for each claim determination period for the Allowable Expenses. If this *Plan* is secondary, the benefits paid under this *Plan* may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

If the rules set forth below would require this *Plan* to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this *Plan*.

## ***ORDER OF BENEFIT DETERMINATION***

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision  
If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).
2. Member/Dependent  
The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.
3. Dependent Children of Parents not Separated or Divorced  
The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.
4. Dependent Children of Separated or Divorced Parents  
When parents are separated or divorced, the birthday rule does not apply, instead:
  - a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
  - b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.
5. Active/Inactive  
The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
6. Longer/Shorter Length of Coverage  
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

## ***COORDINATION WITH MEDICARE***

**NOTE:** For eligible post 65 retirees, benefits will be considered at the *preferred provider* level of benefits.

Individuals may be eligible for *Medicare* Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in *Medicare* Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an *employee* becomes entitled to *Medicare* coverage (due to age or disability) and is still actively at work, the *employee* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching *Medicare* entitlement.
2. When a *dependent* becomes entitled to *Medicare* coverage (due to age or disability) and the *employee* is still actively at work, the *dependent* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching *Medicare* entitlement.
3. If the *employee* and/or *dependent* are also enrolled in *Medicare* (due to age or disability), this *Plan* shall pay as the primary plan. If, however, the *Medicare* enrollment is due to end stage renal disease, the *Plan's* primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in *Medicare* law and regulations. If the *employee* and/or *dependent* does not elect *Medicare*, but is otherwise eligible due to end stage renal disease, benefits will be paid as if *Medicare* has been elected and this *Plan* will pay secondary benefits upon completion of the thirty (30) month "coordination period."
4. Notwithstanding Paragraphs 1 to 3 above, if the *employer* (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) *employees*, when a covered *dependent* becomes entitled to *Medicare* coverage due to *total disability*, as determined by the Social Security Administration, and the *employee* is actively-at-work, *Medicare* will pay as the primary payer for claims of the *dependent* and this *Plan* will pay secondary.
5. If the *employee* and/or *dependent* elect to discontinue health coverage under this *Plan* and enroll under the *Medicare* program, no benefits will be paid under this *Plan*. *Medicare* will be the only payor.
6. For a *retiree* eligible for *Medicare* due to age, *Medicare* shall be the primary payor and this *Plan* shall be secondary. If the *retiree* does not elect *Medicare*, but is otherwise eligible due to age, benefits will be paid as if *Medicare* has been elected and this *Plan* will pay secondary benefits.

This section is subject to the terms of the *Medicare* laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

## ***LIMITATIONS ON PAYMENTS***

In no event shall the *covered person* recover under this *Plan* and all Other Plan(s) combined more than the total Allowable Expenses offered by this *Plan* and the Other Plan(s). Nothing contained in this section shall entitle the *covered person* to benefits in excess of the total *Essential Health Benefits/non-Essential Health Benefits maximum benefit* of this *Plan* during the claim determination period. The *covered person* shall refund to the *employer* any excess it may have paid.

## ***RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION***

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any *covered person*. Any person claiming benefits under this *Plan* shall furnish to the *employer* such information as may be necessary to implement the *Coordination of Benefits* provision.

## ***FACILITY OF BENEFIT PAYMENT***

Whenever payments which should have been made under this **Plan** in accordance with this provision have been made under any Other Plan, the **employer** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this **Plan** and, to the extent of such payments, the **employer** shall be fully discharged from liability.

## ***AUTOMOBILE ACCIDENT BENEFITS***

The **Plan's** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the **covered person's** state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the **Plan** pay any claim presented by or on behalf of a **covered person** for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a **covered expense**, an **employee's** lost wages or a **covered person's** medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event a **covered person** incurs medical expenses as a result of **injuries** sustained in an automobile accident while “covered by an automobile insurance policy,” as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the **Plan** up to the amount equal to that deductible.
2. For the purposes of this section the following people are deemed “covered by an automobile insurance policy.”
  - a. An owner or principal named insured individual under such policy.
  - b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
  - c. Any other person who, except for the existence of the **Plan**, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The **Plan** will be secondary to any potentially applicable automobile insurance even if the state's “financial responsibility law” does not allow the **Plan** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a “financial responsibility” law, the **Plan** is secondary to automobile insurance coverage or to any other person or entity who caused the **accident** or who may be liable for the **covered person's** medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

# SUBROGATION/REIMBURSEMENT

The **Plan** is designed to only pay **covered expenses** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a **covered person** in a time of need, however, the **Plan** may pay **covered expenses** that may be or become the responsibility of another person, provided that the **Plan** later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the **Plan**, as well as by applying for payment of **covered expenses**, a **covered person** is subject to, and agrees to, the following terms and conditions with respect to the amount of **covered expenses** paid by the **Plan**:

1. **Assignment of Rights (Subrogation).** The **covered person** automatically assigns to the **Plan** any rights the **covered person** may have to recover all or part of the same **covered expenses** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the **Plan**. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a **covered person** or paid to another for the benefit of the **covered person**. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the **covered person** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the **Plan** to pursue any claim that the **covered person** may have, whether or not the **covered person** chooses to pursue that claim. By this assignment, the **Plan’s** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
2. **Equitable Lien and other Equitable Remedies.** The **Plan** shall have an equitable lien against any rights the **covered person** may have to recover the same **covered expenses** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the **Plan**. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the **Plan** has paid **covered expenses** prior to a determination that the **covered expenses** arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the **covered person**, the **covered person’s** attorney, and/or a trust) as a result of an exercise of the **covered person’s** rights of recovery (sometimes referred to as “proceeds”). The **Plan** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **plan administrator**, the **Plan** may reduce any future **covered expenses** otherwise available to the **covered person** under the **Plan** by an amount up to the total amount of Reimbursable Payments made by the **Plan** that is subject to the equitable lien.

The provisions of the **Plan** concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

3. **Assisting in **Plan’s** Reimbursement Activities.** The **covered person** has an obligation to assist the **Plan** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the **covered person**, and to provide the **Plan** with any information concerning the **covered person’s** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the **covered person**. The **covered person** is required to (a) cooperate fully in the **Plan’s** (or any **Plan** fiduciary’s) enforcement of the terms of the **Plan**, including the exercise of the **Plan’s** right to subrogation and reimbursement, whether against the **covered person** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the **Plan** as a

co-payee for the amount of the Reimbursable Payments and notifying the **Plan**), (c) sign any document deemed by the **plan administrator** to be relevant to protecting the **Plan's** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **plan administrator** or **claims processor** to enforce the **Plan's** rights.

The **plan administrator** has delegated to the **claims processor** for claims the right to perform ministerial functions required to assert the **Plan's** rights with regard to such claims and benefits; however, the **plan administrator** shall retain discretionary authority with regard to asserting the **Plan's** recovery rights.

# GENERAL PROVISIONS

## ***ADMINISTRATION OF THE PLAN***

The ***Plan*** is administered through the Human Resources Department of the ***employer***. The ***employer*** is the ***plan administrator***. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. Except as otherwise specifically provided in this document, the ***claims processor*** is the ***named fiduciary*** of the ***Plan*** for pre-service and post-service claim appeals. As the ***named fiduciary*** for appeals, the ***claims processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

## ***APPLICABLE LAW***

Except to the extent preempted by federal law, all provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the laws of the State of New York.

## ***ASSIGNMENT***

Coverage and the ***covered person's*** rights under this ***Plan*** may not be assigned. A direction to pay a provider is not an assignment of any right under this ***Plan*** or of any legal or equitable right to institute any court proceeding.

### *Payment of Benefits*

Benefits will be processed as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. All covered health benefits are payable to the ***covered person***. However, the ***Plan*** has the right to pay any health benefits to the service provider. This will be done unless the ***covered person*** has told the ***claims processor*** otherwise by the time the ***covered person*** files the claim and a reasonable amount of time for the ***claims processor*** to process the ***covered person's*** request.

***Preferred providers*** normally bill the ***Plan*** directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider***.

The ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

### *Additional Provisions*

The ***Plan's***, ***plan sponsor's***, ***claim processor's*** failure to implement or insist upon compliance with any provision of this ***Plan*** at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

## ***BENEFITS NOT TRANSFERABLE***

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under the ***Plan***. Such right to benefits is not transferable.

## ***CLERICAL ERROR***

No clerical error on the part of the *employer* or *claims processor* shall operate to defeat any of the rights, privileges, services, or benefits of any *employee/retiree* or any *dependent(s)* hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

## ***CONFORMITY WITH STATUTE(S)***

Any provision of the *Plan* which is in conflict with statutes which are applicable to the *Plan* is hereby amended to conform to the minimum requirements of said statute(s).

## ***EFFECTIVE DATE OF THE PLAN***

The original *effective date* of this *Plan* was January 1, 2018. The *effective date* of the modifications contained herein is January 1, 2019.

## ***FRAUD OR INTENTIONAL MISREPRESENTATION***

If the *covered person* or anyone acting on behalf of a *covered person* makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the *Plan*, or otherwise misleads the *Plan*, the *Plan* shall be entitled to recover its damages, including legal fees, from the *covered person*, or from any other person responsible for misleading the *Plan*, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the *covered person* or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the *Plan* null and void.

## ***FREE CHOICE OF HOSPITAL AND PHYSICIAN***

Nothing contained in the *Plan* shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a *hospital* or to make a free choice of the attending *physician* or *professional provider*. However, benefits will be paid in accordance with the provisions of the *Plan*, and the *covered person* will have higher out-of-pocket expenses if the *covered person* uses the services of a *nonpreferred provider*.

## ***INCAPACITY***

If, in the opinion of the *employer*, a *covered person* for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the *Plan* of the qualification of a guardian or personal representative for his estate, the *employer* may on behalf of the *Plan*, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the *Plan's* obligation to the extent of such payment.

## ***INCONTESTABILITY***

All statements made by the *employer* or by the *employee* covered under the *Plan* shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the *Plan* or be used in defense to a claim unless they are contained in writing and signed by the *employer* or by the *covered person*, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

## ***LEGAL ACTIONS***

The decision by the ***plan administrator/claims processor*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in this ***Plan*** Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan, plan administrator/claims processor***, any other fiduciary, or their employees/retirees, must be filed within one (1) year from the date all claim review procedures provided for in this ***Plan*** Document have been exhausted.

## ***LIMITS ON LIABILITY***

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital***, or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

## ***LOST DISTRIBUTEES***

Any benefit payable hereunder shall be deemed forfeited if the ***plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.

## ***MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS***

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

## ***PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN***

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under the ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

## ***PLAN IS NOT A CONTRACT***

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee/retiree*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee***. Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

## ***PLAN MODIFICATION AND AMENDMENT***

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons***. Any such amendments

shall be in writing, setting forth the modified provisions of the *Plan*, the *effective date* of the modifications, and shall be signed by the *employer's* designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the *Plan* on file with the *employer*, or a written copy thereof shall be deposited with such master copy of the *Plan*. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to *covered persons* shall be timely made by the *employer*.

## ***PLAN TERMINATION***

The *employer* reserves the right to terminate the *Plan* at any time. Upon termination, the rights of the *covered persons* to benefits are limited to claims *incurred* up to the date of termination. Any termination of the *Plan* will be communicated to the *covered persons*.

Upon termination of this *Plan*, all claims *incurred* prior to termination, but not submitted to either the *employer* or *claims processor* within three (3) months of the *effective date* of termination of this *Plan*, will be excluded from any benefit consideration.

## ***PRONOUNS***

All personal pronouns used in the *Plan* shall include either gender unless the context clearly indicates to the contrary.

## ***RECOVERY FOR OVERPAYMENT***

Whenever payments have been made from the *Plan* in excess of the maximum amount of payment necessary, the *Plan* will have the right to recover these excess payments. If the *Plan* makes any payment that, according to the terms of the *Plan*, should not have been made, the *Plan* may recover that incorrect payment, whether or not it was made due to the *Plan's* or the *Plan* designee's own error, from the person or entity to whom it was made or from any other appropriate party.

## ***STATUS CHANGE***

If an *employee/retiree* or *dependent* has a status change while covered under this *Plan* (*i.e.*, *dependent* to *employee*, COBRA to active) and no interruption in coverage has occurred, the *Plan* will provide continuous coverage with respect to any deductible(s), *coinsurance* and *Essential Health Benefits/non-Essential Health Benefits maximum benefit*.

## ***TIME EFFECTIVE***

The effective time with respect to any dates used in the *Plan* shall be 12:01 a.m. as may be legally in effect at the address of the *plan administrator*.

## ***WORKERS' COMPENSATION NOT AFFECTED***

This *Plan* is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

# HIPAA PRIVACY

The following provisions are intended to comply with applicable *Plan* amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*).

## ***DISCLOSURE BY PLAN TO PLAN SPONSOR***

The *Plan* may take the following actions only upon receipt of a *Plan* amendment certification:

1. Disclose protected health information to the *plan sponsor*.
2. Provide for or permit the disclosure of protected health information to the *plan sponsor* by a health insurance issuer or HMO with respect to the *Plan*.

## ***USE AND DISCLOSURE BY PLAN SPONSOR***

The *plan sponsor* may use or disclose protected health information received from the *Plan* to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the *privacy rule*.

## ***OBLIGATIONS OF PLAN SPONSOR***

The *plan sponsor* shall have the following obligations:

1. Ensure that:
  - a. Any agents (including a subcontractor) to whom it provides protected health information received from the *Plan* agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to such information; and
  - b. Adequate separation between the *Plan* and the *plan sponsor* is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).
2. Not use or further disclose protected health information received from the *Plan*, other than as permitted or required by the *Plan* documents or as *required by law*.
3. Not use or disclose protected health information received from the *Plan*:
  - a. For employment-related actions and decisions; or
  - b. In connection with any other benefit or employee benefit plan of the *plan sponsor*.
4. Report to the *Plan* any use or disclosure of the protected health information received from the *Plan* that is inconsistent with the use or disclosure provided for of which it becomes aware.
5. Make available protected health information received from the *Plan*, as and to the extent required by the *privacy rule*:
  - a. For access to the individual;
  - b. For amendment and incorporate any amendments to protected health information received from the *Plan*; and
  - c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *privacy rule*.

7. Return or destroy all protected health information received from the **Plan** that the **plan sponsor** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the **Plan** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
8. Provide protected health information only to those individuals, under the control of the **plan sponsor** who perform administrative functions for the **Plan**; (*i.e.*, eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for **Plan** administrative functions nor to release protected health information to an unauthorized individual.
9. Provide protected health information only to those entities required to receive the information in order to maintain the **Plan** (*i.e.*, claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the **Plan**).
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.
11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the **plan sponsor** on behalf of the **Plan**. Specifically, such safeguarding entails an obligation to:
  - a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the **plan sponsor** creates, receives, maintains, or transmits on behalf of the **Plan**;
  - b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
  - c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
  - d. Report to the **Plan** any security incident of which it becomes aware.

## ***EXCEPTIONS***

Notwithstanding any other provision of this *HIPAA Privacy* section, the **Plan** (or a health insurance issuer or HMO with respect to the **Plan**) may:

1. Disclose summary health information to the **plan sponsor** if the **plan sponsor** requests it for the purpose of:
  - a. Obtaining premium bids from health plans for providing health insurance coverage under the **Plan**;  
or
  - b. Modifying, amending, or terminating the **Plan**;
2. Disclose to the **plan sponsor** information on whether the individual is participating in the **Plan**, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the **Plan**;
3. Use or disclose protected health information:
  - a. With (and consistent with) a valid authorization obtained in accordance with the **privacy rule**;
  - b. To carry out treatment, payment, or health care operations in accordance with the **privacy rule**; or
  - c. As otherwise permitted or required by the **privacy rule**.

# DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

## ***Accident***

An unforeseen event resulting in ***injury***.

## ***Affordable Care Act***

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

## ***Alternate Recipient***

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the ***Plan***.

## ***Ambulatory Surgical Facility***

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by ***Medicare***; or that has a contract with the ***Preferred Provider Organization*** as a ***preferred provider***. An ***ambulatory surgical facility*** is a ***facility*** that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;
2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;
3. Does not provide ***inpatient*** accommodations; and
4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

## ***Approved Clinical Trial***

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other "life-threatening disease or condition" and is further described in accordance with federal law and applicable federal regulations.

## ***Birthing Center***

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

### ***Blue Plan Price:***

When ***covered expenses*** are provided by ***nonpreferred providers***, the allowable amount is based on pricing from the ***Host Blue Plan*** or pricing arrangements required by applicable state or federal law. Federal or state law, as applicable, will govern payments for ***emergency services*** provided by ***nonpreferred providers***. In certain situations, the ***Plan*** may determine the allowable amount based on other pricing methods, such as billed charges, the pricing it would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount payable for services provided by ***nonpreferred providers***. In the situations described in this paragraph, the ***covered person*** may be responsible for the difference between the amount that the ***nonpreferred provider*** bills and the payment by this ***Plan*** for such ***covered expenses***.

### ***Centers of Medical Excellence (CME)***

Health care providers that are designated by the ***claims administrator*** as a selected facility for specified medical services. A provider participating in a ***CME*** network has an agreement in effect with the ***claims administrator*** at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. ***CME*** agree to accept the ***maximum allowed amount*** as payment in full for covered services.

### ***Chemical Dependency***

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) criteria.

### ***Chiropractic Care***

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

### ***Claims Processor***

Refer to the ***Summary Plan Description (SPD)*** section of this document.

### ***Close Relative***

The ***employee/retiree's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee/retiree's*** spouse.

### ***Coinsurance***

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

### ***Complications of Pregnancy***

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy***.

3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during *pregnancy* even if prescribed by a *physician*; morning sickness; or like conditions that are not medically termed as *complications of pregnancy*.

#### ***Concurrent Care***

A request by a *covered person* (or their authorized representative) to the *Health Care Management Organization* prior to the expiration of a *covered person's* current course of treatment to extend such treatment OR a determination by the *Health Care Management Organization* to reduce or terminate an ongoing course of treatment.

#### ***Confinement***

A continuous stay in a *hospital, treatment center, extended care facility, hospice, or birthing center* due to an *illness* or *injury* diagnosed by a *physician*. Later stays shall be deemed part of the original *confinement* unless there was either complete recovery during the interim from the *illness* or *injury* causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the *illness* or *injury* causing the initial stay.

#### ***Copay***

A cost sharing arrangement whereby a *covered person* pays a set amount to a provider for a specific service at the time the service is provided.

#### ***Cosmetic Surgery***

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

#### ***Covered Expenses***

*Medically necessary* services, supplies or treatments that are recommended or provided by a *physician, professional provider* or covered *facility* for the treatment of an *illness* or *injury* and that are not specifically excluded from coverage herein. *Covered expenses* shall include specified preventive care services.

#### ***Covered Person***

A person who is eligible for coverage under the *Plan*, or becomes eligible at a later date, and for whom the coverage provided by the *Plan* is in effect.

#### ***Custodial Care***

Care provided primarily for maintenance of the *covered person* or which is designed essentially to assist the *covered person* in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an *illness* or *injury*. *Custodial care* includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered *custodial care* without regard to the provider by whom or by which they are prescribed, recommended or performed.

**Room and board** and skilled nursing services are not, however, considered **custodial care** (1) if provided during **confinement** in an institution for which coverage is available under the **Plan**, and (2) if combined with other **medically necessary** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the **covered person's** medical condition.

#### ***Customary and Reasonable Amount***

A fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is **incurred** and is comparable in severity and nature to the **illness** or **injury**. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The **customary and reasonable amount** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this **Plan** is 90% and is applied to CPT and CDT codes using Fair Health benchmarking tables. The PPO **negotiated rate** is the **customary and reasonable amount**.

#### ***Dentist***

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a **close relative** of the **covered person**, who is practicing within the scope of his license.

#### ***Dependent***

See the section titled *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility*.

#### ***Durable Medical Equipment***

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an **illness** or **injury**;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered **durable medical equipment**. **Durable medical equipment** includes, but is not limited to: crutches, wheel chairs, **hospital** beds, etc.

#### ***Effective Date***

The date of the **Plan** or the date on which the **covered person's** coverage commences, whichever occurs later.

#### ***Emergency***

An accidental **injury**, or the sudden onset of an **illness** where the acute symptoms are of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the **covered person's** life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

### ***Emergency Services***

With respect to an ***emergency*** medical condition, a medical screening examination that is within the capability of the emergency department of a ***hospital***, including ancillary services routinely available to the emergency department to evaluate such ***emergency*** medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the ***hospital***, as are required to stabilize the patient.

### ***Employee***

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer***, who is regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility* on a ***full-time*** status basis.

### ***Employer***

The ***employer*** is Bedford Central School District.

### ***Essential Health Benefits***

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. ***Emergency services***;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment (***mental and nervous disorder and chemical dependency***);
6. Prescription drugs;
7. ***Habilitative services, rehabilitative services and habilitative and rehabilitative devices***;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

### ***Experimental/Investigational***

Services, supplies, drugs and treatment which do 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 processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator***, or their designee may make an independent evaluation of the ***experimental/non-experimental*** standings of specific technologies. The ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** or their designee will be guided by the experimental/investigational exclusion listed under the section titled *Medical Exclusions*.

### ***Extended Care Facility***

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.
2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.
3. It provides twenty-four (24) hour-a-day nursing services.
4. It maintains a complete medical record on each ***covered person***.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders***.
6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

### ***Facility***

A healthcare institution which meets all applicable state or local licensure requirements.

### ***Fair Allowable Amount:***

Except as otherwise required under state or federal law, the maximum amount the ***Plan*** is obligated to pay for ***covered expenses*** provided by a:

- 1) ***preferred provider*** – the ***preferred provider negotiated rate***;
- 2) ***nonpreferred facility*** – calculated as the lesser of:
  - a) The provider's billed charge; or
  - b) An amount determined by ***claims processor*** or its vendor using one or more of the following:
    - i) Publicly available data reflecting fees typically reimbursed to providers for the same or similar professional services, supplies or treatment, adjusted for geographical differences where applicable; or
    - ii) Publicly available data reflecting the costs for facilities providing the same or similar services, supplies or treatment, adjusted for geographical differences where applicable, plus a margin factor; or
    - iii) An amount negotiated with the ***nonpreferred facility*** for the specific services, supplies or treatment provided.
- 3) ***nonpreferred professional provider*** –
  - a) for claims in excess of \$5000 when ***covered expenses*** are greater than 40% of the total billed charge, an amount negotiated with the ***nonpreferred professional provider*** for the specific services, supplies or treatment provided. If negotiations fail on a ***local claim***, the ***Plan*** will allow the ***customary and reasonable amount*** as a ***covered expense***. If negotiations fail on all other claims, the ***fair allowable amount*** shall be the ***Blue Plan Price***.
  - b) for claims below \$5000, or in excess of \$5000 when ***covered expenses*** are not greater than 40% of the total billed charge, the ***fair allowable amount***:
    - i) shall be the ***customary and reasonable amount*** on all ***local claims***;
    - ii) shall be the ***Blue Plan Price*** on all other claims.

### ***Full-time***

***Employees*** who are regularly scheduled to work not less than the hours per work week as listed in the section titled ***Eligibility, Enrollment and Effective Date, Employee Eligibility***.

### ***Generic Drug***

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

### ***Habilitative Services***

***Medically necessary*** health care services that help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other ***medically necessary*** services for people with disabilities in a variety of inpatient and/or outpatient settings. ***Habilitative services*** that are not ***medically necessary***, for example when therapy has reached an end point and goals have been reached, will not be a ***covered expense***.

### ***Habilitative and Rehabilitative Devices***

***Medically necessary*** devices that are designed to assist a ***covered person*** in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, ***durable medical equipment***, orthotics, prosthetics, and low vision aids.

### ***Health Care Management***

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

### ***Health Care Management Organization***

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***.

### ***Home Health Aide Services***

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

### ***Home Health Care***

Includes the following services: private duty nursing, skilled nursing visits, ***hospice*** and IV Infusion therapy.

### ***Home Health Care Agency***

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.
3. It maintains a complete medical record on each ***covered person***.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under ***Medicare***.

### ***Hospice***

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
2. It is under the direct supervision of a ***physician***.
3. It has a Nurse coordinator who is a Registered Nurse.
4. It has a social service coordinator who is licensed.
5. It is an agency that has as its primary purpose the provision of ***hospice*** services.
6. It has a full-time administrator.
7. It maintains written records of services provided to the ***covered person***.
8. It is licensed, if licensing is required.

### ***Hospital***

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.
2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of ***emergency*** treatment in a ***hospital*** outside of the United States.
5. It must be approved by ***Medicare***. This condition may be waived in the case of ***emergency*** treatment in a ***hospital*** outside of the United States.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

***Hospital*** shall include a facility designed exclusively for physical rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental and nervous disorders*** or ***chemical dependency***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

### ***Host Blue Plan:***

The Blue Cross/Blue Shield plan in which the provider is located.

### ***Illness***

A bodily disorder, disease, physical sickness, or ***pregnancy***.

### ***Incurred or Incurred Date***

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

### ***Injury***

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

### ***Inpatient***

A ***confinement*** of a ***covered person*** in a ***hospital, hospice, or extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

### ***Intensive Care***

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

### ***Intensive Care Unit***

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special lifesaving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

### ***Layoff***

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, active work. ***Layoffs*** will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

### ***Leave of Absence***

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to active work.

### ***Local Claim:***

A claim that is incurred in the State in which the ***Plan*** is situated.

### ***Maximum Benefit [for Essential Health Benefits/non-Essential Health Benefits]***

Any one of the following, or any combination of the following ***Essential Health Benefits/non-Essential Health Benefits***:

1. The maximum amount paid by the ***Plan*** for any one ***covered person*** during the entire time he is covered by the ***Plan***.

2. The maximum amount paid by the **Plan** for any one **covered person** for a particular **covered expense**. The maximum amount can be for:
  - a. The entire time the **covered person** is covered under the **Plan**, or
  - b. A specified period of time, such as a calendar year.
3. The maximum number as outlined in the **Plan** as a **covered expense**. The maximum number relates to the number of:
  - a. Treatments during a specified period of time, or
  - b. Days of **confinement**, or
  - c. Visits by a **home health care agency**.

The **maximum benefit** for **Essential Health Benefits** and non-**Essential Health Benefits** is tracked separately.

### **Measurement Period**

The period of time, as determined by the **employer** and consistent with Federal law, regulation and guidance, utilized by the **employer** to determine whether a **variable hour employee** worked on average 30 hours per week for the **employer**.

### **Medically Necessary (or Medical Necessity)**

Service, supply or treatment which is determined by the **claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator** (or its designee) to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the **covered person's illness or injury** and which could not have been omitted without adversely affecting the **covered person's** condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the **covered person** or the **covered person's** family or **professional provider**; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending **professional provider**.

The fact that a **professional provider** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment **medically necessary** and the **claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator** (or its designee), may request and rely upon the opinion of a **physician** or **physicians**. The determination of the **claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator** (or its designee) shall be final and binding.

### **Medicare**

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

### **Mental and Nervous Disorder**

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

### ***Morbid Obesity***

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the ***covered person***, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

### ***Named Fiduciary for Post-Service Claim Appeals***

CoreSource.

### ***Named Fiduciary for Pre-Service Claim Appeals***

CoreSource.

### ***Negotiated Rate***

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

### ***Nonparticipating Pharmacy***

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

### ***Nonpreferred Provider (Nonpreferred)***

A ***physician***, ***hospital***, or other health care provider who does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

### ***Nurse***

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

### ***Outpatient***

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;
2. A ***physician's*** office, laboratory or x-ray ***facility***; or
3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

### ***Partial Confinement***

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of ***mental and nervous disorders***.

3. **Chemical dependency** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

**Participating Pharmacy**

Any pharmacy licensed to dispense prescription drugs which is contracted within the **pharmacy organization**.

**Part-time**

**Employees** who are regularly scheduled to work less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

**Physician**

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a **close relative** of the **covered person** who is practicing within the scope of his license.

**Placed For Adoption**

The date the **employee** assumes legal obligation for the total or partial financial support of a child during the adoption process.

**Plan**

"**Plan**" refers to the benefits and provisions for payment of same as described herein. The **Plan** is the Bedford Central School District Employee Benefit Plan.

**Plan Administrator**

The **plan administrator** is responsible for the day-to-day functions and management of the **Plan**. The **plan administrator** is the **employer**.

**Plan Sponsor**

The **plan sponsor** is Bedford Central School District.

**Preferred Provider**

A **physician, hospital** or other health care provider who has an agreement in effect with the **Preferred Provider Organization** at the time services are rendered. **Preferred providers** agree to accept the **negotiated rate** as payment in full.

**Preferred Provider Organization**

The organization, designated by the **plan administrator**, who selects and contracts with certain **hospitals, physicians**, and other health care providers to provide services, supplies and treatment to **covered persons** at a **negotiated rate**. The **Preferred Provider Organization's** name and/or logo is shown on the front of the **covered person's** ID card.

**Pregnancy**

The physical state which results in childbirth or miscarriage.

### ***Primary Care Physician (PCP)***

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, gynecologist/obstetrician or general internist and has contracted with the network to render services, supplies and treatment to ***covered persons*** and to assist in managing the care of ***covered persons***.

### ***Privacy Rule***

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

### ***Professional Provider***

A licensed ***physician***; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

### ***Qualified Prescriber***

A ***physician, dentist*** or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

### ***Reconstructive Surgery***

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

### ***Rehabilitative Services***

***Medically necessary*** health care services that help a ***covered person*** get back, keep, or improve skills for daily living that have been lost or impaired after sickness, ***injury***, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. ***Rehabilitative services*** include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

### ***Relevant Information***

***Relevant information***, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

### ***Required By Law***

The same meaning as the term “required by law” as defined in 45 CFR 164.103, or other Federal law.

### ***Retiree***

A former ***employee*** who retired from service of the ***employer*** and has met the ***Plan's*** eligibility requirements to continue coverage under the ***Plan*** as a ***retiree***. As used in this document, the term ***employee*** shall include ***retirees*** covered under the ***Plan***.

**NOTE:** For eligible post 65 retirees, benefits will be considered at the ***preferred provider*** level of benefits.

### ***Room and Board***

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

### ***Semiprivate***

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

### ***Stability Period***

The period of time as determined by the ***employer*** and consistent with Federal law, regulation and guidance, after the ***measurement period*** has been completed.

### ***Total Disability or Totally Disabled***

The ***employee*** is prevented from engaging in his or her regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

### ***Transplant Centers of Medical Excellence maximum allowed amount (CME maximum allowed amount)***

The fee ***CME*** agree to accept as payment for covered services. It is usually lower than their normal charge. ***CME*** maximum allowed amounts are determined by ***Centers of Medical Excellence*** Agreements.

### ***Treatment Center***

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
  - a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
  - b. It provides a program of treatment approved by the ***physician***.
  - c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
  - d. It provides at least the following basic services:
    - (i.) ***Room and board***
    - (ii.) Evaluation and diagnosis
    - (iii.) Counseling
    - (iv.) Referral and orientation to specialized community resources.

***Urgent Care***

An ***emergency*** or an onset of severe pain that cannot be managed without immediate treatment.

***Urgent Care Center***

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;
2. has x-ray and laboratory equipment and life support systems.

An ***urgent care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

***Variable Hour Employee***

An ***employee*** as defined by Federal law, regulation and guidance.

# APPENDIX A

## PROGRAMS AND SERVICES

### ***MESSAGING SERVICES***

Relay Network, LLC provides telephonic messaging, including text messaging, to ***covered persons*** who opt into the service. Such messaging shall include, but not be limited to, information about services and benefits available under the ***Plan***, reminders on preventive care, surveys, and educational information.

Note: The Relay Services Program applies to *covered expenses* under the *Medical Expense Benefit* section only.

### ***MATERNITY PROGRAM***

“Special Delivery” is a voluntary program for expectant mothers offering prenatal information, pre-screening for ***pregnancy*** related risks and information or preparation for childbirth. This program is designed to identify potential high-risk mothers, as well as help ensure a safer ***pregnancy*** for both mother and baby.

Expectant mothers who decide to participate in the “Special Delivery” Program will have access to a twenty-four (24) hour toll-free “babyline” which is staffed by obstetrical nurses.

An expectant mother may participate in this program by calling the number shown on her identification card and asking for a “Special Delivery” nurse. If possible, she should call during the first three (3) months of her ***pregnancy*** in order to receive the full benefits of this program.

### ***TRANSPARENCY TOOL – HEALTHCARE BLUE BOOK***

Healthcare Bluebook is a web-based service, provided by CareOperative, LLC, enabling ***covered persons*** to research medical providers and facilities that offer prices which Healthcare Bluebook considers a “Fair Price” as described below. Services include the following:

**Fair Price information.** Healthcare Bluebook’s Fair Price analysis sets forth what ***covered persons*** should expect to pay for specific procedures in a given geographic area. The core of the Healthcare Bluebook approach is high volume, high-price-variability procedures, called ShopSmart™ procedures, such as colonoscopies, MRIs or knee arthroscopies. For such procedures, Healthcare Bluebook presents information on price ranges, the Fair Price and a list of providers ranked by their price level, allowing ***covered persons*** to identify high-value providers:

- Green means at or below the Fair Price,
- Yellow means for a slightly higher price,
- Red means for a moderately to significantly higher price.

**Provider and Facility Information.** Facility and related physician information, including practice details and Healthgrades quality ratings (or similar) are provided to help ***covered persons*** learn more about the providers listed for ShopSmart procedures.

# ADOPTION

Bedford Central School District has caused this Bedford Central School District Health Benefit Plan (*Plan*) to take effect as of the first day of January 2019, Bedford, New York, New York. This is a revision of the *Plan* previously adopted January 2018. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Bedford Central School District.

BY: \_\_\_\_\_

DATE: \_\_\_\_\_