BEDFORD CENTRAL SCHOOL DISTRICT

Summary Plan Description
for the
Health Benefit Plan

Health Claims Administration By:

POMCO GROUP

Restated January 1, 2011

TABLE OF CONTENTS

INTRODUCTION

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

The Bedford Central School provides a health plan Summary Plan Description (SPD) handbook to eligible and enrolled Employees and Retirees. This SPD handbook shows the following Plan description for the Bedford Central Schools Health Benefit Plan (also shown hereafter as Plan). This Summary Plan Description, the terms of the Plan and any amendments to the Plan make up the Master Plan Document for the Plan. The handbook shows Plan coverage and benefits at the time of publication. To the extent the SPD handbook or other information provided to Plan Enrollees or participants is inconsistent with the Master Plan Document consisting of this document; the terms of the Plan and any amendments to the Plan; the Master Plan Document will govern.

This document updates and replaces previous publications showing coverage for this self-funded Benefit Plan. It is a restatement of Plan coverage showing provisions and benefits in effect as of January 1, 2011.

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

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

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, and eligibility.

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

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. An expense for a service or supply is Incurred on the date the service or supply is furnished.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer that meet the eligibility for Plan enrollment as established by collective bargaining agreements and by established policies of the Bedford Central School District Board of Education. The Bedford Central School District Human Resources Department can provide details concerning your specific eligibility requirements for Plan enrollment.

Eligibility Requirements for Employee/Retiree Coverage. Eligibility rules vary subject to collective bargaining agreements or Bedford Central School District policy. The following are general rules for enrollment eligibility:

(1) is an Active Employee in a class eligible for coverage as defined, subject to collective bargaining agreements or Bedford Central School District policy.

(2) is an eligible Retired Employee of the Employer. An eligible Retired Employee is a Retiree who retired in accordance with the requirements or the retirement program, subject to collective bargaining agreements or Bedford Central School District policy.

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

(1) A covered Employee's Spouse. The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife [of the opposite sex] under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child.

(a) Married or unmarried children are covered from birth to the limiting age of 26 years if they are the Employee's **biological children**, **adopted children, children placed with a covered Employee in anticipation of adoption** or **Foster Children**. **Step-Children** may also be included as long as the biological parent remains married to the Employee. The Dependent child must not be eligible for coverage or covered under another group health plan, fund or policy. **Exception:** coverage of the dependent child under the other parent's group health plan, fund or policy is allowed.

For birth children born to Employee's with individual coverage, the Plan provides benefits for the newborn up to 30 days from birth under the Employee's individual coverage. After 30 days, the newborn must be enrolled in the Employee's family coverage, to be eligible for benefits.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Coverage will not be provided for the initial Hospital stay for treatment of an ill newborn you are in the process of adopting if a child's biological parent has coverage for the child's initial Hospital stay. If a notice of revocation of the adoption has been filed, or if one of the biological parents revokes consent to the adoption, coverage will not be provided. If benefits are paid for an adopted newborn and the adoption is revoked, or one of the biological parents revokes consent, the Employee may be requested to reimburse any benefit payments made for newborn care.

(b) Unmarried children from birth to the limiting age of 19 years who are **primarily supported by the Employee, Spouse or Domestic Partner of the Employee**, and permanently reside in the Employee's home are also eligible for coverage under the Plan. The Dependent child must be primarily dependent upon the covered Employee for support and maintenance. This support and residency must have commenced before the child reached age 19. An unmarried child whose 19th birthday occurs during a school vacation period will continue to be eligible for benefits provided the child is enrolled in a school and is anticipating full-time student status at the end of the school vacation period.

Time spent in the U.S. Military service, not to exceed four years, may be deducted from the Dependent's age for the purposes of establishing eligibility.

The unmarried child may continue to be covered under the Plan after age 19, provided the child is a full-time matriculating student at an accredited secondary school, College or University, receives more than half of their support from the Employee, and under the limiting age of 25.

Federal law mandates that coverage will not terminate if the covered dependent child's failure to maintain full-time status at a postsecondary educational institution is due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating Physician certifies in writing that the child is suffering from a serious Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins.

To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student. If the end of the 12 calendar months occurs during a vacation period, benefits will be extended to the beginning of the next regular semester.

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

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for at least 50% of his or her support and maintenance and the covered Employee must declare the child as a federal income tax deduction.

(c) A Covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the Covered Employee for support and maintenance and unmarried, and became so disabled before reaching the limiting age. This should be done at the time of your initial enrollment if the child is the limiting age or older at the time. If the child has not yet attained the limiting age at the time you first enroll in the Plan, eligibility for continued benefits should be established at the time he or she reaches limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

The phrase "primarily dependent upon" shall mean dependent upon the Covered Employee for at least 50% of his or her support and maintenance and the Covered Employee must declare the child as a federal income tax deduction.

(d) Unmarried Covered Dependents children who are born to the unmarried Dependents enrolled in the Employee's family coverage, the Plan provides benefits for the newborn of the unmarried Dependent up to 30 days under the Employee's benefits. After 30 days, the newborn must meet the requirements of a Dependent child and be enrolled under the Employee's family coverage to be eligible for Plan benefits.

The District Benefits Office may require documentation providing dependency , including birth certificates, tax records(if applicable), or initiation of legal proceedings severing parental rights.

(3) A covered Employee's Domestic Partner. The term "Domestic Partner" shall mean the person recognized as an unmarried Employee's same gender partner with whom the Employee has a committed long term relationship that fully meets the conditions for Domestic Partner eligibility shown below.

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 of the Bedford Central School District:

(i) Joint ownership of property (i.e. real estate), or a joint mortgage or joint lease that is at least 12 months duration.

(ii) Partners have been listed on each other's will for at least twelve months.

(iii) Partners have been a beneficiary of the Employee's ERS or TRS retirement plan for at least twelve months.

(iv) Partners hold general power of attorney or health care power of attorney for each other.

(v) 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.

Please note: The affidavits and documentation you are required to submit are intended only to establish your Domestic Partner as a Dependent under your Plan's family coverage. Individuals, who apply for Domestic Partnership Dependent coverage, are encouraged to consult a tax attorney or accountant

concerning the implications of seeking this coverage in the Plan. As Domestic Partners are not usually recognized as dependents by state, federal, and local taxing authorities, providing this coverage to a Domestic Partner could result in additional tax liability. The District could be required to report the fair market value of the coverage as income on an Employee's W2 form.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; or the legally divorced former Spouse of the Employee.

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

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

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

FUNDING

Cost of the Plan. The Bedford Central School District Benefits Office can provide details of your costs, if any, for Plan participation. If required, you must make your designated participation payments to maintain Plan eligibility. This is usually done by payroll deduction. The enrollment application for coverage may include a payroll deduction authorization. This authorization should be filled out, signed and returned with the enrollment application. If you fail to authorize payroll deductions, you could be refused Plan coverage. If you fail to make direct payment of required participation payments during a Leave of Absence or other available Plan coverage continuation, coverage could end for you and your Dependents.

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

ENROLLMENT

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

(1) Individual coverage. Only the Employee, Retiree, survivor Spouse/Domestic Partner, or a COBRA participant are enrolled. Benefits will be paid only for the person enrolled, even if other family members meet eligibility requirements.

(2) Family coverage. Employee or Retiree and one or more of his or her eligible Dependents are enrolled (includes COBRA participants enrolled in family coverage). Benefits are paid only for family members enrolled in the Plan even if other family members meet eligibility requirements.

If the covered Employee already has Dependent coverage, separate enrollment for a newborn child is required

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan.

Your biological newborn child is covered under your individual or family coverage without Plan enrollment for the first 30 days after the date of birth. However, after 30 days, coverage will not be available unless the child is enrolled as a Dependent in your family coverage.

For children born to unmarried covered Dependent children enrolled in the Employee's family coverage, the Plan provides benefits for the newborn of the unmarried covered Dependent child up to 30 days under the Employee's benefits. After 30 days, the newborn must meet the requirements of a Dependent child and be enrolled under the Employee's family coverage to be eligible for benefits.

If the non-biological newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the Employee does not enroll the newborn in the Plan within 30 days of the date of birth, the newborn will be treated as a late Enrollee and eligible to be added under the "Late Entrant Enrollment" shown later in this document.

ENROLLMENT CHANGES

It is your responsibility to apply for any enrollment changes including:

(1) Adding a newly acquired Spouse/Domestic Partner or Dependent child;

(2) Adding an existing Spouse/Domestic Partner previously enrolled as an Employee;

(3) Adding a previously eligible but non-enrolled Spouse/Domestic Partner or Dependent child;

(4) Changing from individual coverage to family coverage any time you acquire a Spouse/Domestic Partner or Dependent child or elect to enroll a previously eligible but non-enrolled Spouse/Domestic Partner or Dependent child;

(5) Changing from family coverage to individual coverage when you no longer have eligible Dependents or anytime you no longer wish to provide coverage for eligible Dependents;

(6) Changing from two individual coverages to one family coverage or from one family coverage to two individual coverages when you or your Spouse/Domestic Partner are both eligible as Employees under this health Plan.

(7) Changing or adding a new Dependent or removing an existing Dependent from family coverage; or

(8) Reporting other health plan(s) and Medicare coverage information and changes.

TIMELY ENROLLMENT

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

SPECIAL ENROLLMENT PERIODS

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

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

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

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

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

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

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

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

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

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

(2) Dependent beneficiaries. If:

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

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse/Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse/Domestic Partner is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption.

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

(a) in the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;

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

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

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

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

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

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

LATE ENTRANT ENROLLMENT

If you or your Dependents fail to enroll within 30 days of initial eligibility, coverage begins no earlier than the first day of the month following the date the District Benefit Office accepts your late enrollment application. Late entrant rules vary subject to collective bargaining agreements. **Exception:** See "Special Enrollment Periods" shown previously in this document.

EFFECTIVE DATE

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

(1) Employee/Retiree General Rules

(a) Each Employee in an eligible class, whose employment commenced on or before the effective date of the Plan or each eligible Retiree shall be covered on the effective date of the Plan or shall be eligible for any amended changes of the Plan. The eligible Employee must be Actively Employed on such effective dates. However Plan coverage begins no sooner than the first day of the month after the date of eligible employment.

(b) If you enroll at the time of Active Employment, Plan coverage begins on the first day of the month following the date of eligible employment; or

(c) If you enroll at the time of eligible retirement, Retiree coverage begins on your date of retirement; or

(d) If you fail to enroll within 30 days of eligible employment, coverage begins no sooner than the first day of the month following the date the District Benefit Office accepts your late enrollment application. **Exception:** See Special Enrollment periods shown previously in this document.

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

Coverage may be stopped if you or your Dependents knowingly submits a claim, or allows any claim to be submitted with false information, or conceals any facts, that could affect the outcome of a claim determination. 30 calendar days advance notice will be provided. In this case, you or your Dependents cannot continue coverage under COBRA.

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

(1) The date the Plan is terminated.

(2) The end of the month following the day the covered Employee ceases to be in one of the eligible classes. This includes termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.)

(3) The day the covered Employee/ Retiree ceases to be one of the eligible classes due to death of the Employee/Retiree.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. This also applies to an enrolled survivor Dependent.

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

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

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See survivor Dependent; Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse/Domestic Partner loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)

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

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. This also applies to an enrolled Survivor Dependent.

CONTINUATION OF COVERAGE DURING A CERTIFIED DISABILITY OR EMPLOYER APPROVED LEAVE OF ABSENCE

A person may remain eligible for a limited time if Active Employee work ceases due to disability, or approved Leave of Absence. This continuation is not automatic. You must apply for continuation before your disability or approved Leave of Absence starts. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For approved Leave of Absence only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. The District Benefit Office can provide full details concerning your rights for Plan coverage during an approved Leave of Absence or disability. To remain eligible, you must remit your designated participation contribution, if any, to the District each month on a timely basis. The District Benefits Office can answer questions concerning their requirements and provide details on your participation payments. You could be required to pay the total premium equivalent for Plan participation.

CONTINUATION OF COVERAGE DURING FAMILY AND MEDICAL LEAVE

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired must once more enroll in the Plan. The District Benefits Office can provide details on your effective date of coverage following Plan enrollment as a returning Employee.

VESTED EMPLOYEE CONTINUATION OF COVERAGE

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

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

(a) Satisfied the minimum requirements established by law for vesting his or her retirement allowance; and

(b) Met all the minimum requirements except age for Retiree coverage. These requirements must have been met at the time you terminated employment. They must not be satisfied while you are in vested status or after your retirement allowance begins.

(2) Requesting continuation of coverage while in a vested status. If you wish to continue this health Plan while you are vested, you must request continuation of coverage from the District at the time employment is terminated. When the District authorizes continuation of coverage, you will be required to pay your designated plan participation costs from the date you are terminated. The District Benefits Office will assist you with the procedures required to keep your coverage in effect.

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

CONTINUATION OF COVERAGE UNDER USERRA

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

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

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

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

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

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

SURVIVOR DEPENDENTS

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

(1) 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 months following the Employee or Retirees' death. After three months, this extension of eligibility continues to apply to survivors of eligible Retirees or survivors of eligible Employees **who have completed at least ten years of active service with the District**. To be covered, the survivors must request enrollment within 90 days after the death of the Employee or Retiree. **If enrollment is not made within 90 days, eligibility under this rule is not available.** 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 Rights under COBRA" shown later in this document.

(2) 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:

(a) Active Employees who have completed over 10 years of employment with the District, coverage will be provided at no cost for the three 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.

(b) Active Employees who have worked for the District 10 years or less, coverage will be provided at no cost for the two 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 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 Rights under COBRA" shown later in this document.

SCHEDULE OF BENEFITS

Verification of Eligibility 1-800-358-8399

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

COMPREHENSIVE MEDICAL BENEFITS

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

MANDATORY PRECERTIFICATION AND MEDICAL PROCEDURE REVIEW

Note: The following services must be precertified or reimbursement from the Plan may be reduced.
The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

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

Mandatory medical procedure review:

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

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

NETWORK PROVIDER ORGANIZATIONS

The Plan is a plan which contains Network Provider Organizations.

When a Covered Person uses a Network Provider, the Plan will pay the Network Provider directly. The Network Provider agrees to accept the Network scheduled allowance or negotiated allowance as payment in full. The Plan Participant is only responsible for the balance between what the Plan pays and the Network scheduled allowance or negotiated allowance. Out-of-Network Providers are allowed to balance bill up to charges. It is the Covered Person's choice as to which Provider to use.

(1) Network Providers. By choosing a POMCO Network facility, Plan reimbursements are higher than when you choose a PHCS/Multiplan Network facility.

(a) POMCO Network means a facility or Providers that have an agreement with POMCO to bill at negotiated or scheduled rates for covered services. Because the POMCO Network Providers have agreed to charge reduced fees to persons covered under the Plan. the Plan can afford to reimburse a higher percentage of their fees. The Plan agrees to reimburse the Provider directly for covered services.

(b) PHCS/Multiplan Network means a facility or Provider that has an agreement with POMCO to bill at negotiated or scheduled rates for covered services. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan. The Plan agrees to reimburse the Provider directly for covered services.

To find a Network Provider: log onto your Benefitsoft website www.benefitsoft.com, click on "Provider Finder". By choosing POMCO over POMCO-PHCS Multiplan for Hospital and Other Facility services you will receive a higher Plan reimbursement for Covered Charges.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request. Contact: POMCO, 2425 James Street, Syracuse, NY 13206, or call 1-800-358-8399.

OUT OF COUNTRY CARE

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

COORDINATION OF BENEFITS

When services and supplies are rendered and billed by an In-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and/or Medicare Secondary Payer Rules, Network benefits are not available. Benefits will be coordinated as Out-of-Network benefits.

ALLOWED CHARGE

The Allowed Charge is the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for covered medical services rendered and billed by a covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

DEDUCTIBLE/COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

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

A **Deductible** is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

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

Per Event: Means all services rendered by the same Provider on the same day.

PLAN FEATURES

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Comprehensive Medical Benefits, Plan Exclusions, and Definitions.			
Plan Features	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Deductible per Calendar Year	Does not apply to most services. See individual Plan features for exceptions and details.		**$400.00** per individual **$1,375.00** per Family Unit (three or more family members)
Common Accident Deductible	Does not apply to most services. See individual Plan features for exceptions and details.		Family **$400.00** cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan deductible count toward this limit. Expenses also count toward the Calendar Year deductible.
Network Copayment	**$20.00** per Provider per type of service. **Copayment Limit: $60.00** per Covered Person per event (all services by same Provider on same day). Outpatient Network copayment does not apply to the Network copayment limit. See individual Plan features for exceptions and details.		Does not apply.
Benefit Copayment	Applies to a specific benefit In-Network in or Out-of-Network. See individual Plan features for details.		
Percentage Coinsurance	Does not apply to most services. See individual Plan features for exceptions and details.		After deductible, the Plan pays 80% of Allowed non-Hospital Charges up to the Out-of-Pocket limit. See individual Plan features for exceptions and details.

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Comprehensive Medical Benefits, Plan Exclusions, and Definitions.			
Plan Features	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Out-of-Pocket (OOP) Limit per Calendar Year, Excluding Deductible (Percentage coinsurance limit is separate from Hospital percentage coinsurance limit).	Does not apply to most services. See individual Plan features for exceptions and details.		**$1,650.00** per Family Unit. Network copayments, Outpatient Network copayments, benefit copayments, and Hospital coinsurance amounts do not apply.
Outpatient Network Copayment	**$35.00** per visit per Provider for those services listed in the grid. Outpatient Network copayment does not apply to the Network copayment Limit.	Does not apply.	
Hospital Percentage Coinsurance	Does not apply. See individual Plan features for exceptions and details.	The Plan pays 80% of Allowed Hospital Charges up to the Hospital Out-of-Pocket limit. Deductible, Network copayments, Outpatient Network copayments, benefit copayments, and non-Hospital coinsurance amounts do not apply.	
Hospital Out-of-Pocket (OOP) Limit per Calendar Year (Hospital percentage coinsurance limit is separate from percentage coinsurance limit).	Does not apply. See individual Plan features for exceptions and details.	**$1,650.00** per Family Unit. Deductible, Network copayments, Outpatient Network copayments, benefit copayments, and percentage coinsurance amounts do not apply.	
Cost Management Services Program/Pre-notification	If this Plan is primary, this mandatory program requires a phone call before the Covered Person is admitted to a Hospital or Inpatient facility or before specified procedures are scheduled to be performed. For more details, please refer to the section entitled " Cost Management" shown later in this document. You may contact the POMCO Benefit Management Program toll-free at 1-800-358-8399.		

PREVENTIVE CARE

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Preventive Care Benefits, Plan Exclusions, and Definitions.		
Preventive Care	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Well Child Care Exam, Related Testing and Immunizations (to age 18)	100% of Allowed Charges after Network copayment..	Allowed Charges are limited to the POMCO Downstate Network Allowance. You are responsible for any amounts over the Allowed Charges, and an amount equivalent to the applicable Network copayment for services rendered (Copayment amount does not apply to Out-of-Pocket limit maximum).
	Guidelines of the American Academy of Pediatrics (AAP) apply for visit frequency. For a current listing of visit frequency you may access the AAP website at www.aap.org, choose policy site, and then type "Recommendations for Preventative Pediatric Health Care" into search option. Click on the file option called " **Recommendations for Preventative Pediatric Health Care**" to obtain the current AAP clinical frequency recommendations. Coverage for immunizations follows the recommendations set forth by the Advisory Committee on Immunization Practices (ACIP) and/or the recommendations set forth by New York State Insurance Law. Immunizations given later than the recommended age level will still be covered if appropriate and administered to the child before age 18. For a current listing of age appropriate recommended immunizations you may access the CDC website at http://www.cdc.gov/nip/ACIP/default.htm then choose the appropriate link under related links "**Childhood Schedule**" and "**Recommendations**".	
Routine Newborn Nursery Care (includes circumcision)	100% of Allowed Charges **.**	100% of Allowed Charges. Deductible does not apply.
Routine Adult Physicals Over Age 18 (includes exam and age usual related tests, including hearing screening)	**Coverage is available only for eligible Employees, Spouse/Domestic Partner and Dependent children. This benefit is not available to Retirees and their Dependents.**	
	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible does not apply.
	Limited to once every two consecutive Calendar Years. **Benefit limits apply to In-Network and Out-of-Network services combined.**	

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Preventive Care Benefits, Plan Exclusions, and Definitions.		
Preventive Care	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Routine Mammography Screening	**Outpatient Hospital Charges:** 100% of Allowed Charges after $25.00 Benefit copayment. **Other Providers:**100% of Allowed Charges after Network copayment.	**Outpatient Hospital Charges:** 100% of Allowed Charges after $25.00 benefit copayment. **Other Providers:** 80% of Allowed Charges, subject to deductible and Out-of-Pocket limit.
	Limited to: **(1)** Mammography, recommended by a Physician for Covered Persons, at any age, having a prior history of breast cancer, or who have a first degree relative with a prior history of breast cancer. **(2)** A single baseline mammography for Covered Persons 35-39 years of age. **(3)** A mammography every two years for Covered Persons who are 40-49 years of age, or more frequently upon recommendation of a Physician with medical rationale; **(4)** An annual mammography for Covered Persons 50 years of age or older. Includes services rendered in a Hospital Outpatient setting, clinic or Physicians office including interpretation. In no event, will the Plan pay for more than one routine mammography screening in any one Calendar Year. **Benefit maximums apply to In-Network and Out-of-Network services combined.**	
Routine Annual Screening **Pap test and Pelvic Exam** (age 18 and older)	100% of Allowed Charges after Network copayment. Limited to once per 12 consecutive months.	Not a benefit.
Routine Prostate Cancer Screening	The District offers a special program for routine prostate cancer screening exams and related tests. The District will schedule this program once a year. You will receive an announcement showing the scheduled dates, parameters of the program, and a list of the participating healthcare Providers that have been engaged to render the program services.	

Hospital and Other Facility Benefits

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Hospital and other Facilities Benefits, Plan Exclusions, and Definitions.			
Hospital and Other Facility Benefits	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Inpatient Acute Care General Hospital Services (facility charges) Medical or Surgical Care, Maternity Care	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital OOP limit. Deductible does not apply.	
	Limited to 365 days per Spell of Illness or Spell of Accidental Injury. After the Spell of Illness or Spell of Accidental Injury 365 day maximum is met additional covered days are payable at:		
	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
	Pre-certification is required. Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's Average Semi-Private Room Rate, or 80% of its lowest daily rate if it does not have semi-private accommodations whatever its reason for use. Room and board charges for discharge day are not covered. Maternity is covered the same as any other illness. Routine nursery care is covered.		
Certified Birthing Centers	Covered the same as Acute Care General Hospital for services and supplies related to maternity care.		
Inpatient Substance Use Disorder Care (facility charge) • General Hospital • Substance Use Disorder Facility • Partial Hospitalization	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Limited to 365 days per Spell of Illness. After the 365 day Spell of Illness maximum is met additional covered days are payable at:		
	80% of Allowed Charges. Deductible, percentage coinsurance and Out-of-Pocket limit apply.		
	Pre-certification is required. Room and Board charge limited to actual semi-private rate. The charge for a private room is based on the Hospital's Average Semi-Private Room Rate, or 80% of its lowest daily rate if it does not have semi-private accommodations whatever its reason for use. Room and board charges for discharge day are not covered. Two Partial Hospitalization days count as one day towards the Spell of Illness maximum.		
Inpatient Mental Disorder Care (facility charge) • General Hospital • Psychiatric Facility • Partial Hospitalization	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Limited to 365 days per Spell of Illness. After the 365 day Spell of Illness maximum is met additional covered days are payable at:		
	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
	Pre-certification is required. Room and Board charge limited to actual semi-private rate. The charge for a private room is based on the Hospital's Average Semi-Private Room Rate, or 80% of its lowest daily rate if it does not have semi-private accommodations whatever its reason for use. Room and board charges for discharge day are not covered. Two Partial Hospitalization days count as one day towards the Spell of Illness maximum.		
Hospital Outpatient Care Services	**Charges must be billed by the Hospital for its services and supplies. Physician charges are considered separately. Enrollee copayment shown below for certain Network benefits is paid per Covered Person for each Provider per service date. Copayments do not apply if the patient is admitted to the same Hospital from the Outpatient department.**		

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Hospital and other Facilities Benefits, Plan Exclusions, and Definitions.			
Hospital and Other Facility Benefits	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Preadmission Testing (facility charge)	100% of Allowed Charges after a $35.00 Outpatient Network copayment.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Benefits are available for pre-admission testing by a Hospital when all the following conditions are met: **(1)** The surgeon, as a preliminary requirement, orders the tests before you or your Dependent's admission as a registered bed patient for Surgery in a Hospital; **(2)** Tests must be consistent with the diagnosis and treatment of the condition for which the Surgery is needed; **(3)** The reservation for the Hospital bed and operating room was made before testing was done; **(4)** The patient must be physically present at the Hospital for needed tests; and **(5)** Surgery must be scheduled to take place within 14 days after the tests are given. Separate charges for the emergency or Outpatient room are not covered when used for pre-admission testing.		
Emergency Room and Related Services for Medical Emergency (facility charge)	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Initial treatment within 72 hours of an Accidental Injury or within the 12 hours of the first acute symptoms of a sudden and serious Illness. Follow-up care is not covered under this benefit.		
Emergency Room for Non-Medical Emergency (facility charge for emergency room only)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply. Related services are allowed per service type.		
Surgery and Related Services (facility charge)	100% of Allowed Charges after a $35.00 Outpatient Network copayment.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Includes services related to the setting of a fracture or dislocation. However, follow-up services such as suture removal, cast removal, recheck exams etc., are not covered under this benefit. Medically Necessary follow-up services are available under " Other Outpatient Hospital Services and Supplies" shown later in this document. Coverage includes the use of emergency or Outpatient room and related services and supplies on the same day as the Surgery.		
Radiation Therapy	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		
Chemotherapy (includes IV infusion therapy)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply. Related services are allowed per service type. Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Hospital and other Facilities Benefits, Plan Exclusions, and Definitions.			
Hospital and Other Facility Benefits	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Kidney Dialysis or Medicare Certified Dialysis Center (facility charge)	100% of Allowed Charges.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		
Respiratory Therapy (facility charge)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
Speech Therapy (facility charge)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
	Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		
Cardiac Rehabilitation (facility charge)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
	Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		
Physical Therapy/Occupational Therapy (facility charge) • Physical/Occupational therapy that starts within 6 months and is rendered within 365 days after related Surgery or after discharge from related Inpatient Hospitalization • Other Medically Necessary Physical/Occupational therapy	Please refer to "Medical Surgical Services and Supplies" found later in this document for coverage criteria. Separate charges for the emergency or Outpatient rooms are not covered.		
	100% of Allowed Charges after a $35.00 Outpatient Network copayment per visit.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
Diagnostic X-ray , Lab, and Machine Tests(facility charge)	Routine Preventive Care is not covered under this benefit. See separate benefit for routine limited Preventive Care coverage available, shown previously under "Preventive Care" in the Schedule of Benefits.		
• Patient present	100% of Allowed Charges after a $35.00 Outpatient Network copayment.	80% of Allowed Charges subject to the Hospital Out-of-Pocket limit. Deductible does not apply.	
• Patient not present	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Hospital and other Facilities Benefits, Plan Exclusions, and Definitions.			
Hospital and Other Facility Benefits	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Hospital Outpatient Clinic Visit (clinic charge only)	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply. Related services are allowed per service type.		
Other Outpatient Hospital Services and Supplies	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply. Benefits are available for other Outpatient Hospital services and supplies when ordered by the attending Physician and found Medically Necessary. To be eligible for benefits, the medical care must otherwise be covered under the Plan. Such services are subject to the same criteria and limitations applied to the same type of services covered under "Medical Surgical Services and Supplies" found later in this document.		
Ambulance • Hospital owned for emergency transportation to nearest Hospital or owner Hospital	100% of Allowed Charges. Deductible does not apply.		
• Professional ambulance or Hospital owned ambulance not fitting above criteria	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
• Volunteer ambulance	100% of Allowed Charges up to maximum of $25.00 (donation) per Calendar Year. Deductible does not apply. Proof of donation must be submitted.		
Freestanding Ambulatory Surgical Center	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.		
Inpatient Skilled Nursing Facility (SNF)/Rehabilitation Facility Care	100% of Allowed Charges. Deductible does not apply. **Pre-certification required.** Limited to 150 benefit days per Spell of Illness or Spell of Accidental Injury. Once the 150 day Spell of Illness or Spell of Accidental Injury limit is met no further SNF benefits are available for that Spell of Illness or Accidental Injury. SNF benefit days count towards the Hospital 365 day Spell of Illness or Spell of Accidental Injury limit. **If you or your Dependents are eligible for Medicare primary coverage, according to Medicare Secondary Payer rules, Inpatient SNF care is not covered.**		
Outpatient Skilled Nursing Facility (SNF)/ Rehabilitation Facility Care	**Per service type.** See respiratory therapy, physical therapy, speech therapy, and cardiac rehabilitation etc., shown later in this document under "Medical Surgical Services and Supplies" for benefit limits and Coverage criteria.		

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Hospital and other Facilities Benefits, Plan Exclusions, and Definitions.			
Hospital and Other Facility Benefits	**POMCO Network Benefits**	**PHCS/Multiplan Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Home Health Care (HHC) Agency Service and Supplies One HHC visit equals • Up to 4 hours of home health aide care; or • Each visit by other covered members of the HHC team	100% of Allowed Charges. Deductible does not apply.		
	Pre-certification required. Limited to up to 365 days per Spell of Illness or Spell of Accidental Injury. Three visits by a member of the Home Health Care team equals one benefit day. Benefit days count towards the Hospital 365 Spell of Illness or Spell of Accidental Injury limit. Once the 365 day Spell of Illness or Spell of Accidental Injury limit is met, no further HHC benefits are available for that Spell of Illness or Accidental Injury.		
Hospice Care Agency	100% of Allowed Charges. Deductible does not apply.		
	During this period of Hospice acceptance, all the patient's medical services must be provided by our obtained through the Hospice Agency.		

MEDICAL/SURGICAL SERVICES AND SUPPLIES

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Surgical Charge Benefits (Physician charges)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Anesthesia (Physician charges)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Transplants	**Per service type.** Please refer to Transplants in the section titled "Medical Surgical Services and Supplies" shown later in this document for coverage criteria.	
In-Hospital/Facility Physician's Care (Physician charges)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Coverage for visits is only provided for days approved for a covered Inpatient stay. Substance Use Disorder Inpatient rehabilitation visits are not covered under this benefit.	
Inpatient Consultation (Physician charges)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Limited to one consultation per specialty for each Hospital confinement for any combination of In-Network and Out-of-Network Providers.	

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Outpatient Consultation (Physician charges)	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Second Opinion Consultation (Physician charges)	**Includes exam, necessary tests, and written report. Limited to initial second opinion and one additional opinion if the second opinion did not agree with the first opinion.**	
• Mandatory second opinion (mandated by Cost Management Program	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
• Voluntary second opinion (obtained through Cost Management Program)	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
• Second opinion consultation (not obtained through Cost Management Program)	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Outpatient Provider Care Office Visit (Physician charges)	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Consultations, surgical and obstetrical procedures, Mental Disorder Care, Substance Use Disorder Care, and rehabilitation therapies, are covered separately as shown later in this document.	
Foot Care and Podiatry Services	**Per service type:** Please refer to Foot Care and Podiatry Services found in the section titled “Medical Surgical Services and Supplies” found later in this document for Coverage criteria.	
Emergency Room Visit (Physician charges)	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Diagnostic X-ray	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Diagnostic Machine Tests	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Laboratory Tests	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance OOP limit apply.
Allergy Testing	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Allergy Injections	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Allergy Serum	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Professional Interpretation Charges	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance , and Out-of-Pocket limit apply.

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Kidney Dialysis in Office or Home	100% of Allowed Charges. Deductible does not apply. Professional evaluation and management of the Illness is covered separately.	
Radiation Therapy	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Chemotherapy (includes IV infusion therapy)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Outpatient Treatment of Substance Use Disorders	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	For an Approved Plan of Care for Outpatient services rendered by a Substance Use Disorder Facility for the diagnosis and treatment of a Substance use Disorder.	
Outpatient Treatment of Mental Disorders	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Services must be given and billed by a medical doctor(psychiatrist) or a licensed clinical psychologist (Ph.D.), Registered Licensed Clinical Social Worker or billed by a Hospital or a mental health facility, Physician's corporation or clinic for the Services of a licensed psychiatrist, licensed clinical psychologist or Licensed Clinical Social Worker.	
Psychological Testing	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Physical Therapy	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Speech Therapy	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Occupational Therapy	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Occupational therapy is only covered if part of an approved therapy treatment plan to restore bodily function lost due to disease or Injury or loss of body part.	
Cardiac Rehabilitation	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Inhalation Therapy	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Professional Nursing • Inpatient Private Duty Nursing Care	Not a benefit.	
• Outpatient Private Duty Nursing Care	The charges for the first 48 hours of covered services per 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 Agency Services and Supplies" shown previously in this document.	
	100% of Allowed Charges following the 48 hour exclusion up to a $30.00 per hour benefit limit for an Approved Plan of Care. **Network Providers may balance bill up to Network Allowance.**	80% of Allowed Charges following the 48 hour exclusion, subject to Deductible. Allowed Charges are limited to $30.00 per hour for an Approved Plan of Care. Charges more than $30.00 per hour are not covered. Percentage coinsurance, and Out-of-Pocket limit apply.
• Visiting Nursing	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Durable Medical Equipment (DME)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Pre-authorization is required for DME rental or purchase when costs are expected to exceed $100.00. **Physician's prescription required.** Coverage includes necessary supplies to operate the DME. Duplicate equipment, service or delivery charges are not covered. Specialized equipment is excluded when standard equipment is adequate for the patient's condition. Plan covers rental up to purchase price.	
Oxygen	100% of Allowed Charges.	80% of Allowed Charges. Deductible, Percentage Coinsurance, and Out-of-Pocket Limit apply.
	Physician's prescription required.	
Medical/Surgical Supplies (home use)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Ostomy bags and supplies, catheters and supplies, syringes and needles.	
Prosthetics/Orthotics	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Physician's prescription required. Prosthetic devices or Orthotics must replace physical organs or parts, or aid in their function. Replacement will only be considered for coverage when needed due to a change in the patient's body condition. Specialized equipment is excluded when standard equipment is adequate for the patient's condition. Biomechanical Devices are excluded. Specifically excluded are foot Orthotics or other foot devices and supports used for foot disorders, except when needed after an open cutting surgical procedure. Also excluded are supports, devices and Orthotics used for athletic use. Duplicate equipment, and service or delivery charges are not Covered. Wigs and eyeglasses/lenses are covered as shown below.	
Wigs	100% of allowed Charges up to a benefit maximum of $250.00 for the initial wig or hairpiece ordered by a Physician for hair loss due to chemotherapy or radiation therapy. Limited to one wig/hairpiece per Covered Person per Lifetime. Deductible does not apply.	

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Therapeutic Injections	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Blood Services	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
Contact Lens/Eyeglasses following Intraocular /Cataract Surgery	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Limited to: initial pair of eyeglasses or contact lenses.	
Diabetic Supplies/Equipment	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Pre-authorization is required for external insulin pump rental or purchase when costs are expected to exceed $100.00.	
Diabetic Education	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Plan pays up to three visits per Covered Person on initial diagnosis of diabetes and up to three visits per Covered Person each time a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. **Benefit limit applies to In-Network and Out-of-Network services combined.**	
Dental Care	**Per service type rendered.** Limited coverage, please refer to Dental Care found in the section titled "Medical Surgical Services and Supplies" found later in this document for Coverage criteria.	
Chiropractic Care	100% of Allowed Charges after Network copayment.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
	Limited to: $750.00 per Calendar Year per Covered Person for any combination of In-Network And Out-of-Network services combined.	
Artificial Insemination (AI)/ Intra-uterine Insemination(IUI)	**Per service type:** Limited coverage, please refer to "Artificial Insemination/Intra-uterine Insemination" found in the section titled "Medical Surgical Services and Supplies" found later in this document for coverage criteria.	
Bariatric Surgery for Treatment of Morbid Obesity	**Per service type. Precertification required.** Limited coverage for Medically Necessary (as determined by the Claims Administrator) bariatric Surgery. Bariatric Surgery is limited to once per Covered Person per Lifetime.	
Biofeedback	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	100% of Allowed Charges.	80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply.

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Medical/Surgical Services and Supplies Benefits, Plan Exclusions, and Definitions.		
Medical/Surgical Services and Supplies	**Network Benefits**	**Out-of-Network Benefits** (Providers are allowed to balance bill the difference between the Allowed Charges and actual charges)
Prescription Drugs • This Plan is Primary	**Benefit only available through CVS/Caremark Prescription Benefits shown later in this document.**	
• This Plan is Secondary	**Benefits not available through CVS/Caremark, benefits are paid under Medical Benefits.** 80% of Allowed Charges. Deductible, percentage coinsurance, and Out-of-Pocket limit apply. Plan benefits are coordinated with the primary plan's benefits. Drugs are covered or exclude on the same basis as those shown under "Prescription Drug Benefits' shown later in this document.	

PRESCRIPTION DRUG BENEFIT

The following Summary of Benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to Prescription Drug Benefits, Plan Exclusions, and Definitions.		
If this Plan is primary coverage is available from CVS/Caremark. If this Plan is secondary coverage is available under your Medical benefits shown above.		
Allowable fees are limited to the CVS/Caremark Network drug allowance even if a Out-of-Network Pharmacy is used. If you use a Network Pharmacy, you are responsible only for the copayment. If you use a Non-participating Pharmacy or do not show your Plan identification card, you are responsible for payment of the copayment and the charges more than the drug allowance and you must submit your claim to CVS/Caremark to receive Plan benefits.		
Covered Services	**Network Pharmacy**	**Out-of-Network Pharmacy**
Retail Pharmacy (Limited to 34-day supply or 100-dosage unit, whichever is greater)	**Drug Copayments:** **Specified Drugs**: $15.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur. **All other Covered drugs:** **Generic:** $ 10.00 for each prescription or refill. **Brand Name:** $ 30.00 for each prescription or refill.	
Mail Order Pharmacy (up to a 90 day supply)	**Mail Order Copayment:** **Specified Drugs:** $20.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur. **All other Covered drugs:** **Generic:** $13.00 for each prescription or refill. **Brand Name:** $35.00 for each prescription or refill.	Not a Benefit

COST MANAGEMENT SERVICES

Precertification or preauthorization does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to POMCO Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered.

Cost Management Services Phone Number

POMCO: 1-800-358-8399

Please refer to the Employee ID card for the Cost Management Services phone number.

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

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least seven days in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum Out-of-Pocket payment.

UTILIZATION REVIEW

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

The program consists of:

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

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

(2) **Mandatory Medical Procedure Review**:

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

(3) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

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

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

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

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

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

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

Here's how the program works.

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services (see listed services on page above in subsection entitled" UTILIZATION REVIEW"), the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least seven days before** services are scheduled to be rendered with the following information:

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

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

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

> If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by **$250.00**.

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

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

MEDICAL PROCEDURE REVIEW - SECOND AND/OR THIRD OPINION PROGRAM

Mandatory Procedure Review

Certain medical, diagnostic, or surgical procedures are performed either inappropriately or unnecessarily.

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

For the procedures listed above in the subsection entitled" UTILIZATION REVIEW" , Mandatory Medical Procedure Review, you must call the POMCO Cost Management Department whenever you or your Dependent are scheduled for one of these procedures. The purpose of this phone call is to decide if a second opinion is required. Your phone call will start the medical review process. POMCO will mail its determination to you within two business days after their evaluation which could include contact with the Physician.

You or your covered Dependent may be required by the POMCO Cost Management Department to obtain a Second Opinion Consultation.

Benefits will be provided for a second (and an optional third, if the second opinion does not agree with the first opinion) opinion consultation to determine the Medical Necessity of an elective surgical procedure or medical or diagnostic procedure.

Failure to follow the procedure will reduce reimbursement received from the Plan.

> If the Covered Person does not receive a second opinion as explained in this section, or if the second opinion is not waived by the POMCO Cost Management Department, benefit payment for the charges billed by the surgeon will be reduced by **50%** of Allowed Charges up to a maximum of **$250**.

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

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

POMCO 1-800-358-8399 (the number listed on the Member's ID card)

to receive information on how to obtain a second opinion to confirm the need for the Surgery or procedure.

These additional consultations must be performed by Physicians who are:

(1) Board Certified Specialists in the area in which the operation or procedure is concerned; and

(2) not financially associated with either the Provider originally recommending Surgery or procedure or, in the case of a third opinion, with each other.

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

If the second opinion does not confirm the need for Surgery or procedure, a third opinion is allowed.

Voluntary Procedure Review

If you or your eligible Dependent is scheduled for a surgical procedure not listed under “Mandatory Medical Procedure Review”, you may want a second opinion before you decide to proceed with the procedure. If this Plan is primary when you or your eligible Dependent are scheduled for a surgical procedure not listed under “Mandatory Medical Procedure Review”, you may call the POMCO Managed Care Department to request a voluntary second opinion consultation. It is advisable to allow two (2) weeks for scheduling the second opinion consultation.

If you use a Network Provider from the POMCO Provider Network for the second opinion consultation, full payment will be made to the Provider for that opinion. If you do not use a Network Provider for a second opinion consultation, full reimbursement for that opinion will be based on the Usual, Reasonable and Customary Charges. If a second opinion consultation is not obtained through this program, usual Plan benefits will apply.

CASE MANAGEMENT

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

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

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

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

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

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

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

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

COMPREHENSIVE MEDICAL BENEFITS

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

DEDUCTIBLE

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

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

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

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

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

BENEFIT PAYMENT

Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

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

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

COVERED CHARGES

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

PREVENTIVE CARE

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

Charges for Routine Well Child Care:

Well Newborn Nursery/Physician Care: The benefit is limited to the Allowed Charges made by a Physician for routine pediatric care for the first four days after birth while the newborn child is Hospital-confined. Your biological child is eligible for coverage for 30 days from the moment of birth under your individual or family coverage. Charges for covered routine newborn care will be applied toward the Plan of the covered parent. However, after 30 days, coverage will not be available unless the child is enrolled as a Dependent under your family coverage. For children born to unmarried covered Dependent children enrolled in the Employee's family coverage, the Plan provides benefits for the newborn of the unmarried covered Dependent child up to 30 days under the Employee's benefits. After 30 days, the newborn must meet the requirements of a Dependent child and be enrolled under the Employee's family coverage to be eligible for benefits. Other eligible newborns must be enrolled in your family coverage to be eligible from the moment of birth.

- Routine well child care is routine care by a Physician that is not for an Injury or Sickness, to include health care visits, related testing, and immunizations.
- Coverage for health care visits is intended to be consistent with the clinical standards set forth by the American Academy of Pediatrics. If these standards change, the Plan will automatically cover the new recommended standards.
- Coverage for immunizations follows the recommendations of the Advisory Committee on Immunization Practices and/or as set forth by New York State Insurance law. If these standards change, the Plan will automatically cover the new recommended standards.

Charges for Routine Well Adult Care

Routine well adult care is care by a Physician that is not for an Injury or Sickness.

- Routine Adult Physical Exams, to include related screening tests (Active Employees and their covered Dependents only)
- Routine Mammography
- Gynecological Exam and Pap Smear
- Routine Prostate Cancer Screening

HOSPITAL AND OTHER FACILITIES

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

INPATIENT HOSPITAL CARE

The medical services and supplies furnished by a Hospital or a Birthing Center.

(1) Benefits for room and board charges. The Usual and Reasonable Charges for room and board are payable as described in the Schedule of Benefits.

The Plan pays the Average Semi-Private Room Rate for room and board charges by a Hospital or other covered Inpatient health facility. If the Inpatient facility does not have a semi-private rate, the rate shall be 80% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Coverage for private room charges will be limited to the Average Semi-Private Room Rates, whatever the reason for private room use.

(2) Benefits for special charges (miscellaneous charges). The Allowed Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

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

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

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

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first four days after birth while the newborn child is Hospital confined as a result of the child's birth.

Your biological child is eligible for coverage for 30 days from the moment of birth under your individual or family coverage. Charges for covered routine newborn care will be applied toward the Plan of the covered parent. However, after 30 days, coverage will not be available unless the child is enrolled as a Dependent under your family coverage. Other eligible newborns must be enrolled in your family coverage to be eligible from the moment of birth.

INPATIENT SUBSTANCE USE DISORDER CARE.

Regardless of any limitations on benefits for Substance Use Disorders treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Substance Use Disorder will be subject to the benefit payment maximums shown in the Schedule of Benefits for services by a Substance Use Disorder Facility for an Approved Plan of Inpatient Care, including approved Partial Hospitalization stays. The Plan of Care must be approved for coverage through the Cost Management Program. Private room charges are limited to the Average Semi-Private Room Rates, whatever the reason for use. Room and board charges for the date of discharge are not covered.

Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits.

All treatment is subject to the benefit payment percentages shown in the Schedule of Benefits.

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

INPATIENT MENTAL DISORDER CARE

Regardless of any limitations on benefits for Mental Disorders treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the Schedule of Benefits. Care for treatment of diagnosed Mental Disorders is only allowed when the patient requires such care for the protection of himself or others or when the course of treatment can only be carried out on an Inpatient basis. Private room charges are limited to the Average Semi-Private Room Rates, whatever the reason for use. Room and board charges for the date of discharge are not covered. Services must be given and billed a Hospital or Psychiatric Facility including approved Partial Hospitalization stays.

Counseling or therapy primarily rendered for marital, family and sexual problems, educational services (including dysfunctional or vocational training), or custodial care. Recreation and personal items are not covered.

OUTPATIENT HOSPITAL CARE

Services and supplies payable are:

(1) Preadmission testing service. The diagnostic lab tests and X-ray exams payable as described in the Schedule of Benefits.

(2) Outpatient emergency accident care, emergency medical care, and non-Medical Emergency care.

(a) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within72 hours of the accident is payable as described in the Schedule of Benefits.

(b) Care for the initial treatment of a Medical Emergency, as defined in this Plan, within 12 hours of the onset of the Medical Emergency is payable as described in the Schedule of Benefits.

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

(3) Outpatient surgical care.

(4) Outpatient therapy services after an Injury or Sickness. Are payable as described in the Schedule of Benefits.

(a) Radiation therapy.

(b) Chemotherapy (includes IV infusion therapy).

(c) Dialysis in a Hospital or Medicare-certified dialysis center.

(d) Physical therapy.

(e) Occupational therapy.

(f) Respiratory therapy.

(g) Speech therapy.

(5) Outpatient diagnostic services.

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

(b) Laboratory and pathology.

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

(6) Clinic services or supplies.

(7) Other Outpatient Hospital services or supplies. Benefits are available for other Outpatient Hospital services and supplies when ordered by the attending Physician and found Medically Necessary. To be eligible for benefits, the medical care must otherwise be covered under the Plan. Such services are subject to the same criteria and limitations applied to the same type of services covered under “Medical Surgical Services and Supplies” found later in this document.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

AMBULANCE CHARGES

The Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Transfer from a Hospital to another Hospital or Inpatient facility will be considered when the transfer is necessary because the first facility could not provide the necessary care ant the patient required ambulance transportation to the nearest Hospital or Inpatient facility that could provide the needed care.

Air or sea ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air or sea ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance.

For professional or Hospital owned ambulance, services are covered when ordered by a police officer or Physician for transportation to the nearest Hospital that can provide treatment for the patient's Illness or Injury, even if that service is later found not Medically Necessary by the Claims Administrator.

Benefits are not payable if the patient could have been safely transported by any other means of transportation. No other types of transportation are covered, whatever the reason. Coverage is not provided for travel or transportation of persons other than the patient, such as medical personnel, family or friends, whatever the reason.

AMBULATORY SURGICAL CENTER

Ambulatory Surgical Center, as defined, for Outpatient Surgery.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

SKILLED NURSING FACILITY (SNF) CARE

(1) Inpatient SNF Services. The room and board (semi-private room rate only, private-room charges over the semi-private room rate are excluded), nursing care, rehabilitative therapy, ancillary or miscellaneous medical services or supplies, appliances and equipment furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) care is Medically Necessary and at a skilled level of care according to Plan provisions. Skilled care is care of an acute nature that must be furnished by skilled personnel (qualified technical or professional health personnel) on a daily basis. In no event are benefits available for Custodial Care, Maintenance Care, nursing home, residential, long-term care or any care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution;

(c) coverage will only be provided for as long as Inpatient care in a general Hospital would have been necessary if care in a Skilled Nursing Facility were not provided;

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility;

(e) diagnostic and therapeutic services must be provided and billed by the facility and rendered by employees of the facility.

(f) If Medicare is the primary payer (according to Medicare Secondary Payer rules), Inpatient care is not covered. This applies whether or not the eligible person is enrolled in Medicare. This exclusion also applies if Medicare benefits for skilled nursing facility charges are exhausted.

Covered Charges for a Covered Person's care in these facilities is limited to the day maximum shown in the Schedule of Benefits.

(2) Outpatient SNF Services. To be eligible for coverage, medical services and supplies must otherwise be covered under the Plan. Covered services are subject to the same benefit limitations to include:

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

(b) Other Outpatient Services and Supplies. Benefits are available for other Outpatient facility service or supplies when found Medically Necessary according to Plan provisions.

HOME HEALTH CARE SERVICES AND SUPPLIES

Charges for Home Health Care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Care must be pre-approved for coverage through the Cost Management Program and based on written recommendation by the attending Physician.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. Services must be rendered and billed by an accredited and certified Home Health Care Agency.

The following services are covered under this benefit:

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

(2) Part-time or intermitted Home Health Aide services rendered primarily for the care of the patient. Full-time care is not covered;

(3) Rehabilitative physical, occupational and speech therapy;

(4) Medical supplies, drugs and medicines that would have been allowed if the patient were confined in a Hospital or other Inpatient facility;

(5) Laboratory services that would have been covered if rendered during an Inpatient stay in a Hospital or Skilled Nursing facility; and

(6) If your Physician or the Home Health Care Agency considers it Medically Necessary,

(a) Radiology and EKG services; social services by medical social worker;

(b) Ambulance or ambulette transportation services between your home and the Hospital, if it is necessary for your care.

HOSPICE CARE SERVICES AND SUPPLIES

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

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Benefits are available for the following Hospice Services and Supplies when rendered as part of an Approved Hospice Care Plan:

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

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

(3) Home care and Outpatient services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a Home Health Aide;

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

(5) Medical social services and nutritional services;

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

(7) Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;

(8) Durable Medical Equipment;

(9) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency; and

(10) Bereavement counseling for covered family members any time during Hospice care or within one year after the patient’s death.

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

MEDICAL/SURGICAL SERVICES AND SUPPLIES

SURGICAL CHARGE BENEFITS

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

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

Care and treatment for voluntary surgical sterilizations are covered.

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

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

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

ASSISTANT SURGEON

Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure, (a Hospital rule or requirement does not , in itself, establish Medical Necessity.) The assistance must be in a Hospital or other facility where there is no qualified staff available to assist the surgeon. The Maximum Payment for all assistant surgeons for each surgical procedure is 20% of the value listed for the surgical procedure.

ANESTHESIA

Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee other than an Advanced Physician care Extender.

The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after Surgery. Anesthesia administration expenses are not covered if the Surgery is not covered by the Plan.

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

MATERNITY

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

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

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your covered Dependents. The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth, cesarean section or other termination of a Pregnancy will include the usual care given by a provider before and after the obstetrical procedure (prenatal or postnatal care).

RECONSTRUCTIVE SURGERY

The Plan covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive Surgery that is incidental to or follows Surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive Surgery because of a congenital disease or anomaly of a Dependent child that has resulted in a functional defect.

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

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

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

(3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

TRANSPLANTS - Organ/Autologous Bone Marrow/Stem Cell

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

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

(1) Recipient Expenses. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient’s transplant Surgery and recovery; and post discharge care.

(2) Donor Expenses.

(a) Coverage includes expenses Incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) *to the extent such charges are not reimbursed by the donor's plan.*

(b) If you or your Dependent act as a donor, the donor expenses ***will not*** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. No benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member.

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

IN-HOSPITAL/FACILITY PHYSICIAN'S CARE BENEFITS

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

However, a medical charge will not include:

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

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

Limited to one visit per day. However, additional Physician visits will be considered when found Medically Necessary. Prolonged visit during a critical period of Illness that requires constant bedside attendance by the Physician will be limited to a total of five hours per visit. The prolonged critical care visit must be found Medically Necessary according to Plan provisions. Care by more than one Physician will be considered when each Provider gives medically required treatment for separate and different conditions.

SPECIALIST CONSULTATIONS

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. The specialist exam will not be considered a consultation when referral is made by friends, relatives or by a Physician who is not considered an attending Physician. The consultation must be given by a board-certified Physician specialist whose specialty is appropriate to render an opinion for that person's condition. This benefit includes the exam, necessary tests and written reports. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the specialist consultant is required primarily due to Hospital rules or regulations, benefits will not be paid. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

(1) Inpatient Consultations. Coverage is limited to one Inpatient consultation per specialty for each Inpatient stay.

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

(3) Second Opinion Consultation. Benefits are available for second opinion consultations before proceeding with a covered Surgery or procedure. **Please refer to the "Cost Management Program" section of this document for a listing of those procedures that require a second opinion consultation and how to obtain one**. If the second opinion does not agree with the first opinion you or your Dependent may seek a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second (or third) opinion consultation. It is the patient's decision whether to undergo the procedure.

PHYSICIAN CARE

The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, Outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, Mental Disorder Care, Substance Use Disorder care, and rehabilitation therapies, are covered separately.

FOOT CARE AND PODIATRY SERVICES

Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Services or supplies for routine foot care, foot Orthotics, orthopedic shoes or shoe inserts are not covered, except when needed for open cutting procedures (please refer to "Plan Exclusions").

DIAGNOSTIC TESTING, X-RAY AND LAB CHARGE BENEFITS

Diagnostic Testing, X-ray and Laboratory charges are the Allowed Charges for X-rays and laboratory tests. Routine or preventative tests are not covered unless specifically included otherwise in the Plan. Hospital charges for X-rays, machine tests and lab charges are covered separately under " Hospital Benefits" shown previously in this document. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

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

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

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

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

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

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

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

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

KIDNEY DIALYSIS

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

RADIATION/CHEMOTHERAPY BENEFITS

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

(1) Radiation Charge and Limits

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

Radiation charges will not include charges for diagnostic or cosmetic procedures.

(2) Chemotherapy Charge and Limits

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

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

Coverage includes services, supplies and equipment for an Approved Plan of Care. A phone call is required before home care therapy begins. Please see the “Cost Management Program” section shown previously in this document for details.

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not covered under this chemotherapy benefit. When purchased at a Pharmacy, the chemotherapy drugs are generally available for coverage under “Prescription Drug Benefits” shown later in this document.

SUBSTANCE USE DISORDER OUTPATIENT CARE

Regardless of any limitations on benefits for Substance Use Disorders treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Substance Use Disorder will be subject to the benefit payment maximums shown in the Schedule of Benefits for services by a Substance Use Disorder Facility for an Approved Plan of Outpatient Care. To be considered for benefits, the Claims Administrator must approve the Plan of Care for Plan coverage.

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits. Each visit must consist of at least one of the following: individual or group counseling; activity rehabilitation therapy; or diagnostic evaluations by a Physician or other licensed professional to decide the nature and extent of the patient's Illness. Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature. Services must be rendered by the employees of the facility, for services provided by the facility.

MENTAL DISORDERS OUTPATIENT CARE

Regardless of any limitations on benefits for Outpatient Mental Disorder treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Outpatient Mental Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the Schedule of Benefits. Covered Charges for care, and treatment of Mental Disorders will be limited as follows:

- Provider's visits are limited to one individual and one group therapy treatment per day, unless additional visits are found Medically necessary according to Plan provisions.

- Services must be given and billed by a medical doctor (psychiatrist), licensed clinical psychologist (Ph.D.), or a Registered Licensed Clinical Social Worker or billed by a Hospital or a mental health facility, Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or a Registered Licensed Clinical Social Worker. **No other Providers are covered.**

Benefits are not payable for care that is primarily directed at raising the level of consciousness, social enhancements, retraining, professional training or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups. Under no circumstances are benefits provided for therapy that includes the satisfaction of requirements for professional training.

PROFESSIONAL NURSING CARE

Nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service as shown in the schedule of benefits and will be included to this extent:

(1) Inpatient Private Duty Nursing Care. Not a benefit, whatever the reason.

(2) Outpatient Private Duty Nursing Care. Charges are covered only when ordered by a Physician and care is Medically Necessary and not Custodial in nature. **The charges for the first 48 hours of covered services for private duty nursing in a Calendar Year are excluded.** Services must be provided by and require the skills of a registered professional nurse (RN) to manage the care of acutely ill patients and must not be ordered primarily at the request of a relative or Household Member. Benefits are not available for Custodial or Maintenance Care or care that is primarily assistance with daily living or other services that do not require the skills of an RN. A licensed practical nurse (LPN,LVN) may be allowed if the Physician certifies that a registered nurse is unavailable for a portion or shift of 24-hr skilled nursing care.

(3) Visiting Nursing. Part-time or intermittent visiting nurse services are allowed when rendered in the patient's home and ordered by the attending Physician. Care must be billed by a certified visiting nurse agency or by a state or country visiting nurse service for professional nurse services. Home Health Care benefit covered separately as shown previously in this document.

REHABILITATION THERAPY

Benefit limits are described in the Schedule of Benefits for:

(1) Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable. Exercise programs and use of body exercise equipment is not covered.

(2) Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable. Speech therapy is not covered for stammering, stuttering, lisping or mild articulation disorders. Benefits are not available for myofunctional or tongue thrust therapy.

(3) Occupational therapy Occupational therapy is only covered if part of an approved therapy treatment plan to restore bodily function lost due to disease or Injury or loss of body part through short-term therapy.

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

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an Approved Plan of Care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related physician exams and evaluations will be considered separately as physician visits. Separate charges for use of exercise equipment are not covered.

(5) Inhalation therapy for short-term outpatient inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified provider. Custodial Care or Maintenance Care is not covered.

DURABLE MEDICAL EQUIPMENT (DME)

Rental of Durable Medical or surgical Equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions**. Pre-authorization is required for DME rental or purchase when costs are expected to exceed $100.00.** These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless Covered by a warranty or purchase agreement. Charges for delivery and service are not Covered. External insulin pumps are covered when found Medically Necessary for the treatment of diabetes.

PROSTHETICS

The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition or is no longer repairable (wear and tear) to make the original device no longer functional.

WIGS

Charges associated with the initial purchase of a wig for cancer patients up to the maximum listed in the Schedule of Benefits.

ORTHOTICS

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

OXYGEN (Home Use)

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

MEDICAL SUPPLIES (Home Use)

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

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

(2) Catheters and supplies required for their use.

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

BLOOD SERVICES

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

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled Surgery that customarily requires blood transfusions.

CONTACT LENS/EYEGLASSES

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

DIABETIC SUPPLIES, EQUIPMENT, AND EDUCATION

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

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

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

(c) Injection aids;

(d) Cartridges for the legally blind;

(e) Syringes;

(f) Data management systems;

(g) External insulin pumps or insulin infusion pumps when Medically Necessary and when conventional injection therapy is found to be inadequate to treat the patient's condition.

Items such as alcohol, swabs, adhesive tape and gauze are not covered.

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

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

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

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

DENTAL CARE

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

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(2) Emergency repair due to Injury to Sound Natural Teeth within 12 months of the Injury.

(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(4) Excision of benign bony growths of the jaw and hard palate.

(5) External incision and drainage of cellulitis.

(6) Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, surgical extraction of teeth, treatment of cavities, periodontal disease and preparing the mouth for the fitting of or continued use of dentures even if connected with the medical procedure. TMJ appliances or similar devices and related services are not covered.

CHIROPRACTIC CARE

Spinal Manipulation/Chiropractic services by a licensed doctor of chiropractic (D.C.) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. Coverage is for active or Maintenance Care and includes office visits, manual manipulations, diagnostic services and other usual care for this type of treatment. Plan benefits are limited to $750.00 per Covered Person per Calendar Year.

ARTIFICIAL INSEMINATION (AI)/INTRA-UTERINE INSEMINATION (IUI)

Coverage is limited to AI or IUI 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 ovulatory cycles per course of treatment when rendered within two consecutive years. **The course of treatment must be pre-approved for coverage by the Claims Administrator.** To obtain coverage approval for a course of AI or IUI, the Physician must provide a statement of Medical Necessity including details on condition, medical history, previous Infertility or AI/IUI treatment and proposed treatment plan. The Claims Administrator will advise whether coverage is available according to Plan limitations and exclusions. Benefits are limited to the following:

(1) Initial course of AI/IUI up to six ovulatory cycles within two 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 expenses.

(3) If the initial course of treatment is successful (results in confirmed Pregnancy) within six cycles, coverage becomes available for a second course of AI/IUI treatment when pre-approved for coverage by the Claims Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent AI/IUI 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. 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 shown above. **Coverage is not provided for other care such as in-vitro fertilization; 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.

PRESCRIPTION DRUGS

If this Plan is primary, benefits are not available under your medical benefits. Coverage is available under "Prescription Drug Benefits" shown later in this document. Benefits are administered by the Prescription Claims Administrator.

If this Plan is secondary, coverage is not available through your Prescription Drug Claims Administrator. Coverage is available under your Medical benefits administered by POMCO. You must submit your claims for benefits to the primary carrier for benefit determination, then to POMCO for benefit consideration. Benefits will be coordinated according to the rules shown in the section entitled "Coordination of Benefits" shown later in this document. Coverage will be based on URC charges. Otherwise, drugs are covered or excluded on the same basis as those shown under the section entitled " Prescription Drug Benefits" shown later in this document.

DEFINED TERMS

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

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

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

Allowed Charge(s) are the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for covered medical services rendered and billed by a covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

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

Approved Plan of Care is any service or course of treatment approved for benefits by the Claims Administrator under the terms and limitations of the Plan.

Average Semi-Private Room Rate is the standard semi-private rate in the Hospital or facility. If the Hospital does not have a semi-private rate shall be deemed to be 80% of the room and board charges made by the Hospital or facility for its lowest priced room accommodations. If the Hospital has several semi-private rates, the prevailing, or the most common rate, shall be used. Semi-private accommodations are usually rooms with two or more beds.

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

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

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 30th of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

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

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

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

Dependent is an Enrollee's legal Spouse, Domestic Partner or an Enrollee's child who meets the conditions shown in the section entitled "Eligibility" shown previously in this document.

Domestic Partner or Domestic Partnership means an unmarried Employee's same gender partner with whom the Employee has a committed long term relationship that fully meets the conditions established for Domestic Partner eligibility shown in the section entitled "Eligibility" shown previously in this document.

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

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

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

Durable Medical Equipment must be prescribed by a Physician.

Employee means any person who is considered an Employee of the District according to the eligibility requirements of the Plan. Former Employees or Retirees may also be designated Employees if so designated by the District eligibility requirements.

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

Employer is Bedford Central Schools.

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

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

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

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

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

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

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

If any of the entities used to determine the Investigational status of a drug, a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will not make payment for related retroactive Incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

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

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

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

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

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care services and supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

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

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

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required; or Medicare must approve it for Hospice care.

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

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

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative Surgery on the premises.

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

Household Member means any person sharing a common abode as part of a single family unit, including domestic employees and others who live together as part of a Family Unit, but not including a mere roomer or boarder.

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

Immediate Relative of patient or Enrollee - Any of the following:

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

Incurred means those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

Infertility means the inability to achieve a Pregnancy after 12 months of unprotected intercourse.

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

Inpatient or Inpatient Care is the period during which you are treated at a Hospital or a Skilled Nursing Facility/extended care facility or other facility as a registered bed patient for whom room and board charges are made.

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

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

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

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

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

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claim Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

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

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network Provider is an organization, Physician, Hospital, Pharmacy or other professional healthcare provider that at the time covered services or supplies are provided, is part of the participating network(s) selected by the Plan. The Network Provider has a contract or agreement with the Network organization and the Claims Administrators to bill negotiated charges or allowances for covered services or supplies when Incurred by Covered Persons.

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

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

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

Out-of-Pocket means the patient liability portion of the percentage coinsurance.

Outpatient or Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, the patient's home, or other care not rendered on an Inpatient basis.

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

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Registered Licensed Clinical Social Worker(for care of Mental Disorders), Midwife, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Bedford Central Schools Health Benefit Plan, which is a benefits plan for certain Active Employees and Retired Employees of Bedford Central School District and is described in this document.

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

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

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

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

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

Provider - Any legally licensed Physician or any physical therapist, speech therapist, Registered Licensed Clinical Social Worker (for Mental Disorder care), or other health care providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Skilled Nursing Facility, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for covered services given by covered Physicians or other healthcare providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility: A private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations as an Inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorder.

Registered Licensed Clinical Social Worker is a licensed social worker with at least six years of post degree experience who has been certified with an "r" registration by the New York State Board for Psychiatric Social Work or similar qualifications outside New York.

Retired Employee or Retiree is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

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

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

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

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

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

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

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

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

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

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

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

Spouse means the legal wife or husband (of the opposite sex) of an eligible Employee or Retiree.

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

Substance Use Disorder Facility - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Use Disorder Services (OASAS) for the Outpatient treatment of Substance Use Disorder (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organization for the Outpatient treatment of Substance Use Disorder.

Surgery means any of the following:

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

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

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by Physicians to treat medical conditions not requiring Inpatient or Outpatient Hospital care, and which is not a Physician's office.

Usual, Reasonable and Customary Charge (URC) is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period is the period of time between the Employee's date of eligibility and/or hire and the date the Employee becomes covered under the Plan.

PLAN EXCLUSIONS

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

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

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

(1) **Anesthesia.** Services or supplies for the administration of anesthesia for any Surgery or treatment that is not covered by the Plan.

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

(3) **Birth control.** Services or supplies related to family planning, oral contraceptives or other birth control devices, whatever the reason.

(4) **Blood Donations.** Services or supplies for autologous or directed blood donations and/or storage when done as a precautionary measure in case the need for blood arises. Exception: Autologous or directed donation services and supplies preceding Surgery as specifically included in the Plan.

(5) **Cosmetic.** Services or supplies connected with elective cosmetic Surgery or treatment. Reversal of elective, cosmetic Surgery will not be covered unless found to be Medically Necessary according to Plan provisions. **Exception:** Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive Surgery that is incidental to or follows Surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive Surgery because of a congenital disease or anomaly of a Dependent child that has resulted in a functional defect.

(6) **Counseling/Analysis/Support Groups**. Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups.

(7) **Custodial Care or Maintenance Care.** Services or supplies provided mainly as a rest cure, Maintenance or Custodial Care. **Exception:** Chiropractic care as allowed up to benefit maximum.

(8) **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances or other related services for treatment of temporomandibular joint disorders (TMJ) or similar disorders. **Exception:** Charges by a dentist or a Physician for care otherwise considered medical such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, or freeing of muscle attachments. Limited dental care given for Accidental Injury to Sound Natural Teeth within 12 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

(9) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.

(10) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical developmental for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, birth defects, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest Mental Disorder or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

(11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(12) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. **Exception:** Care specifically included under the section entitled “Preventive Care” or voluntary sterilization expenses.

(13) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Services and supplies related to vision therapy. **Exception:** This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the section entitled “Preventive Care”.

(14) **Family counseling.** Counseling and consultation services with members of the family other than the patient. **Exception:** Family member counseling under the Plan coverage for mental Disorder care, Substance Use Disorder and bereavement counseling under Hospice Agency Care.

(15) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes, foot Orthotics or other supportive foot devices are specifically excluded unless when needed following open cutting corrective procedures of the foot.

(16) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(17) **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

(a) Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

(b) State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.

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

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

(e) USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.

(f) Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

(18) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after cancer treatments.

(19) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. **Exception:** Services covered under the section entitled “Preventive Care”. and F.D.A. approved cochlear implant will be covered under the Plan's Prosthetic benefit.

(20) **Home medical supplies.** Medical supplies for home use that are not directly supplied by as part of an Approved Plan of Care for Home Health Care or Hospice services, or that is not needed for the operation of covered Durable Medical Equipment. Specifically excluded are items primarily intended for comfort or to support activities of daily living. Exceptions: Covered ostomy supplies, catheters and related supplies, covered syringes and needles, or certain diabetic supplies as specifically included in the Plan.

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

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

(23) **Immediate Relative/Household Member or self giving professional services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as an Immediate Relative as defined, whether the relationship is by blood or exists in law.

(24) **Infertility.** Care, supplies, services and treatment for infertility, or in vitro fertilization. **Exception:** Surgical or medical procedures directed at treatment of an identifiable organic disease or organic disorder will be considered the same as any other Illness and artificial insemination or intra-uterine insemination as specifically included in the Plan.

(25) Late claim filing. Services or supplies for which an adequate claim is not filed with the Claims Administrator within the Plan time limit for claim submissions. Claims must be submitted no later than 90 days after the end of the Calendar Year in which the covered expenses were Incurred. Exceptions may be made at the discretion of the Claims Administrator or the Plan Administrator for the late claim filing due to extenuating circumstances beyond the control of the Enrollee.

(26) Midwife/Doctor duplicate services. Services that are duplicates because they are provided by both a nurse midwife and Physician.

(27) Military Service. Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

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

(29) No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

(30) Non-acute facilities. Services or supplies rendered in a place of rest, a placed for the aged, a nursing home or in an educational facility, a place mainly for care of alcoholism, drug addiction, Mental Disorders or tuberculosis unless the facility meets the Plan requirements for Skilled Nursing Facility coverage, Substance Use Disorder Facility coverage or Inpatient Mental Disorder coverage.

(31) No obligation to pay. Charges Incurred for which the Plan has no legal obligation to pay.

(32) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(33) Not specified as covered. Non-traditional medical services, treatments and supplies (example: alternative medicine including but not limited to acupuncture, holistic medicine and hypnotherapy) which are not specified as covered under this Plan.

(34) Not included. Services or supplies that are not included as covered expenses under the Plan even if ordered by a Physician. Covered services or supplies that are rendered, provided and/or billed by a Provider that is not included for Plan coverage even if Medically Necessary. This applies even if such services, supplies or Providers are not specifically excluded according to Plan provisions.

(35) Obesity/diet management/exercise. Care and treatment of obesity, weight loss, exercise programs or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric Surgery reversal. **Exceptions:** Limited coverage specifically shown in the Plan for professional telemetric monitoring during cardiac rehabilitation, occupational or physical therapy, diabetic education and Medically Necessary (as determined by the Claims Administrator) bariatric Surgery for documented Morbid Obesity.

(36) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.

(37) Occupational therapy. Charges in connection with occupational therapy that is primarily directed at activities of daily living or occupation. **Exception:** Occupational therapy that is part of an Approved Plan of Care for Home Health Care, Hospice or Inpatient care in an approved facility and occupational therapy directed at functional body improvement as specifically included under rehabilitative therapy benefits.

(38) **Orthotics (foot).** Charges in connection with foot Orthotics. **Exception:** When needed following open cutting corrective procedures of the foot.

(39) **Other Plan/Benefit Penalties/Primary Care Network/HMO Network**. Services or supplies to the extent such expenses were disallowed by a primary health plan due to failure by their enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care Physician network established by a health maintenance organization or similar organization that is a primary plan payer.

(40) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.

(41) **Plan penalties/Deductibles/Copayments/Benefit Limits.** Services or supplies to the extent they are not reimbursed due to benefit penalties, deductibles, copayments or other limits under any portion of this Plan. **Exception:** When this Plan is secondary payer to another plan according to the "Coordination of Benefits" provision we will consider the other plan's deductible, copayments and benefit limits.

(42) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Plan provisions.

(43) **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(44) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment.

(45) **Skilled Nursing Facility Inpatient care with Medicare.** Services or supplies billed by a Skilled Nursing Facility (SNF) for Inpatient care when Medicare is the primary plan according to Medicare Secondary Payer rules. The Plan will not pay any Inpatient expenses billed by the SNF including, but not limited to, Medicare deductible, coinsurance and charges Incurred after Medicare is exhausted. This applies to the person eligible for Medicare whether or not enrolled.

(46) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches or other drugs even if ordered and recommended, ordered or prescribed by a Physician.

(47) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions) other than from an insurance carrier under an individual policy issued to you or your Dependent. **Exception:** Conditional payments shown in the section entitled " Third Party Recovery Provision".

(48) **Surgical Assistance**. Expenses billed for surgical assistance in a Hospital if the Hospital has qualified staff Physicians to provide such assistance.

(49) **Surgical sterilization reversal.** Care and treatment for surgical sterilization reversals.

(50) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for newborns who meet the child eligibility requirements and who are enrolled under family coverage.

(51) Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services as specifically included in the Plan.

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

PRESCRIPTION DRUG BENEFITS

IF THIS PLAN IS PRIMARY

If this Plan is primary, benefits are available from the Prescription Drug Claims Administrator CVS/Caremark as shown in this section.

IF THIS PLAN IS SECONDARY

If this Plan is secondary, coverage is not available through your Prescription Drug Claims Administrator. Do not show your Bedford Schools identification card at the Pharmacy or submit any prescription claims to the CVS/Caremark mail service Pharmacy. If you or you're covered Dependent(s) obtain drugs through CVS/Caremark when another plan is primary, you will be responsible for reimbursement of any Plan overpayments.

Coverage is available under your Medical benefits administered by POMCO. You must submit your claims for benefits to the primary carrier for benefit determination, then to POMCO for benefit consideration. Benefits will be coordinated according to the rules shown in the section entitled "Coordination of Benefits" shown later in this document. Coverage will be based on URC charges. Please refer to the section entitled "Medical/Surgical Services and Supplies", subsection "Prescription Drugs" shown previously in this document. Otherwise, drugs are covered or excluded on the same basis as those shown under the section entitled "Prescription Drug Benefits" shown below.

PHARMACY DRUG CHARGES

Participating Network Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CVS/Caremark is the administrator of the Pharmacy Drug Plan. You and your covered Dependents may purchase drugs from any Pharmacy. However, if this Plan is considered the primary payer and you and your covered Dependents choose a CVS/Caremark Network Pharmacy or use the CVS/Caremark Mail Service for maintenance drugs, you save costs for yourself and your Employer.

COPAYMENTS

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the "Schedule of Benefits". The copayment amount is not a covered charge under the Medical Plan. Any one retail Pharmacy prescription is limited to the lesser of a 34-day supply or 100 doses. Any one mail service prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, you must pay the Pharmacy and submit a claim to CVS/Caremark for reimbursement. The amount payable in excess of the amounts shown in the "Schedule of Benefits" will be based on the CVS/Caremark Network drug allowance as determined by the Claims Administrator.

MANDATORY GENERIC DRUG SUBSTITUTION PROGRAM

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

(1) Noncompliance Benefit Reduction. Under the CVS/Caremark program, if you or your eligible Dependent receives a Brand Name drug when a generic substitution is available, you are responsible for paying the difference between the cost of the Brand Name drug and the Generic Drug and the applicable copayment for the Brand Name drug. Drug costs will be based on the participating Pharmacy prices as established by CVS/Caremark. This can result in substantial payment by you as there may be a significant difference in costs between the expensive Brand Name drug and the lower priced Generic Drug.

(2) Medical Exception. If the attending Physician considers the generic substitute to be harmful to the Covered Person's health, then the Plan will allow coverage for the costs of the Brand Name drug. To qualify for this exception, the Physician must provide written specific reasons why the Generic Drug is harmful to you or your Dependent's health. This exception will not apply if the Physician just wants to prescribe that particular Brand Name drug. Your Physician may fax his/her written statement to POMCO at 315-433-5447. It will be promptly reviewed and if approved, you will be able to obtain the Brand Name drug each time it is purchased. If you have any questions concerning this procedure, you may contact the clinical co-coordinator for the POMCO Pharmacy Program at 1-800-836-0709.

Benefits will continue to be paid for Brand Name drugs, which have no Generic Drug equivalent.

NETWORK PHARMACY

A Network Pharmacy has an agreement with the Prescription Drug Claims Administrator, CVS/Caremark to accept the Plan benefit, after any applicable copayment, as payment in full. If this Plan is the primary coverage, you or your Dependents may purchase covered drugs at a CVS/Caremark Network Pharmacy .

If this Plan is primary, you need only present your **Plan identification card** and the written prescription at any CVS/Caremark Network Pharmacy, then pay the applicable copayment amount. The Pharmacy will bill CVS/Caremark directly and will receive direct payment from them. If you do not present your Plan identification card at the time of purchase, you must file your own claim, and benefits will be paid as if the drug was purchased at an Out-of-Network Pharmacy. Refer to the subsection entitled "Out-of-Network Pharmacy" shown later in this section.

MAIL ORDER DRUG BENEFIT OPTION

If this Plan is primary, the Mail Order Drug Benefit Option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). In addition, acute care medications with prescriptions written for more than 21 days (one refill) may be obtained through the mail order option. Because of volume buying, CVS/Caremark, the mail order Pharmacy, is able to offer Covered Persons significant savings on their prescriptions. This service delivers the drug directly to your home and you are only liable for the applicable copayment. To obtain drugs through the mail order drug benefit:

(1) When the Physician writes a prescription for a "maintenance drug" (one taken regularly or on a long-term basis) he or she should indicate the number of refills allowed.

(2) For your first mail order, complete the supplied patient profile/registration form (obtainable from the District). Enclose the completed form in the self-addressed envelope with the original prescriptions written by the Physician, then mail to the mail order pharmacy.

(3) For original and refill prescriptions, complete the supplied order form. A new order form and envelope will be mailed with each delivery.

(4) The medication will be delivered to your or your Dependent by first class mail or UPS. You should allow 10-14 working days from the time the prescription forms are mailed to the mail order Pharmacy until delivery of your medications. However, to ensure you or your Dependents are not left without an adequate supply of medication, you should order when you or your Dependents have a minimum of a 30-day supply of the current medication. Drugs cannot be filled at a retail Pharmacy while the mail order is being processed.

CVS/Caremark
P.O. Box 270
Pittsburgh, PA 15230-9949
1-888-645-9303

OUT-OF-NETWORK PHARMACY

If this plan is primary and you or your Dependents purchase covered drugs at a Out-of-Network Pharmacy or do not use your Plan identification card at a Network Pharmacy, you must pay the Pharmacy and submit your claims for benefits to CVS/Caremark for reimbursement. Benefits will be based on the CVS/Caremark Network drug allowance as determined by the Claims Administrator, less the applicable copayment. Any charges over the CVS/Caremark Network allowance will be your liability and will not be reimbursed. To file a claim for benefits, a drug claim form must be obtained from the District personnel office. The original drug receipt (receipt should include date of purchase, names of drug, dose and RX #.) and the completed drug claim form should be mailed to:

CVS/Caremark
P.O. Box 2860
Pittsburgh, PA 15230-2860

COVERED PRESCRIPTION DRUGS

Unless otherwise shown, all drugs must be ordered by the attending Physician and found Medically Necessary.

(1) Medications that require a prescription by a licensed Physician and are federal legend drugs.

(2) Compounded medications containing at least one prescription ingredient in therapeutic amounts.

(3) Diabetic insulin, syringes, lancet auto-injectors, and lancets.

(4) Injection delivery devices (syringes) for uses other than diabetic when necessary for self-administration of covered injectable legend drugs.

(5) Tretinonoin topical for Medical Necessity with a prescription. Pre-authorization is required for Covered Persons.

(6) Prenatal vitamins or other vitamins obtainable only with Physician's prescription.

(7) Allergy emergency kits for emergency treatment of insect stings in allergic patients.

(8) Drugs for treatment of impotency, Caverject, Muse, Edex and forms of testosterone used for treatment of impotence. Sildenalfil Citrate (Viagra or similar drug) when pre-authorized through POMCO. A

written request for Viagra pre-authorization should be sent to the POMCO Benefits Management Department with attending Physician's statement showing Medical Necessity.

(9) Other drugs that under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

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

LIMITS TO THIS BENEFIT

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

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

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

EXPENSES NOT COVERED

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants/dietary/vitamin supplements/nutritional products.** A charge for appetite suppressants, dietary supplements, vitamin supplements or nutritional products, except for prenatal vitamins requiring a prescription.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Contraceptives or birth control**. Any contraceptive or birth control drug or device.

(5) **Cosmetic medications.** Cosmetic medications including, but not limited to anti-wrinkle medications, dermatological medications, hair growth medications, any drugs approved by the FDA for cosmetic use only.

(6) **Devices.** Devices of any type, even though such devices may require a prescription, including contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device, unless specifically shown as a covered prescription drug expense.

(7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Fluoride prep and dental rinses.**

(10) **Immunization agents/ allergy extracts.** Immunization agents or biological sera and allergy extracts.

(11) **Implantable time-released medications** (example: Norplant).

(12) **Inpatient medication.** 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 the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(14) **Medical exclusions.** A charge excluded under “Medical Plan Exclusions”.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or other drugs/items specifically shown as covered under this benefit.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(18) **Smoking deterrents.** Smoking deterrents whether or not Physician prescribed.

HOW TO SUBMIT A CLAIM

SUBMITTING MEDICAL BENEFITS

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the provider with written authorization.

When the claim is processed, POMCO will send you an Explanation of Benefits Statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accurately.

When a Covered Person has a medical claim to submit for payment that person must:

(1) Obtain a claim form from the Personnel Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or dentist complete the Provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

POMCO
PO Box 6329
Syracuse, New York 13217-6329
Telephone 1-800-358-8399

SUBMITING PRESCRIPTION DRUG BENEFITS

Prescription Claims Administrator is CVS/Caremark; please refer to the section entitled”Prescription Drug Benefits” for information on how to submit Prescription Drug claims.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator as services are Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Notice and/or proof of claims must be submitted by March 31 of the Calendar Year following the Calendar Year in which the covered expenses were Incurred. Claims filed later than that date may be declined or reduced unless:

(1) it's not reasonably possible to submit the claim in that time; and

(2) this claim deadline period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS APPEAL PROCEDURE

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

(a) The specific reasons for the denial; and

(b) Information about how to submit the claim for review.

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

(a) May request in writing that the Claims Administrator review the denial;

(b) May review pertinent documents; and

(c) May submit issues and comments in writing, stating the reason or reasons for the disagreement with the claims determination in clear and concise terms.

Following the receipt of the written request for review and any supporting information submitted with the request, the Claims Administrator will fully and fairly review the previous claim determination. The decision on review shall be made by the Claims Administrator within 60 days of the receipt of the request for review, unless special circumstances require an extension of time for independent investigation concerning the merits for the denied claim, in which case a decision shall be rendered as soon as possible, but not later than 120 days after the receipt of the request for review. If such extension of time is required, written notice of the extension shall be furnished to the claimant before the end of the original 60-day period. The decision on review shall be made in writing, and shall include specific references to the provisions of the Plan on which the denial is based. If the decision is not furnished within the time frame specified above, the claim shall be deemed denied on review and the

claimant shall be allowed to exercise the right to pursue any other legal or equitable remedy otherwise available. If the participant continues to disagree with the appeal review, then he or she may request a final review as shown below. For all purposes under the Plan, the decision on the appeal review (unless final appeal review requested) shall be final, binding and conclusive on all interested parties as to participation relating to the Plan.

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

The final appeal must be in writing and sent to the Plan Administrator within 30 days after receipt of the full or partial denial of benefits based on the initial claim appeal decision. The Committee may, in its sole discretion, accept the appeal after such time has elapsed if, in their opinion, extenuating circumstances prevented the participant from making a claim during such period. If necessary, the Plan Administrator will delete or 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. The arbitrator cannot add to, modify or deviate from the terms of the health Plan.

LEGAL PROCEEDINGS

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

COORDINATION OF BENEFITS

COORDINATION OF BENEFIT PLANS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse/Domestic Partner is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. **Exception:** See also Medicare Integration described below.

BENEFIT PLAN

This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare or Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

ALLOWED CHARGE

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

For Medicare integration, see section below.

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only and vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

(c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

RIGHT TO RECEIVE OR RELEASE INFORMATION

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

RIGHT OF RECOVERY

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

MEDICARE

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

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

This Medicare integration provision applies to all persons eligible for primary Medicare coverage even if the person is not actually enrolled in Medicare

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

MEDICARE PAYMENT INTEGRATION

The Plan determines the allowable fee first, then subtracts Medicare's payment from the allowable fee. Any difference will be subject to the Plan's usual benefit calculation.

NOT ENROLLED IN MEDICARE

This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare or incurs services in a Veterans Administration Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

MEDICARE PRIVATE CONTRACT OPTION

This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain providers, Medicare will not pay. The patient is responsible for the entire charge. The provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

MEDICARE PART C (MEDICARE ADVANTAGE)

This integration will not apply when Medicare and a Medicare-sponsored Advantage Plan deny coverage due to its enrolled beneficiaries failure to abide by the HMO or participating provider program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

MEDICARE ALLOWABLE FEES

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

(1) If the provider accepts Medicare assignment of benefits, the Allowable Fees will be the same fees allowed by Medicare.

(2) If the provider does not accept Medicare assignment, the Allowable Fees will be based on the Usual, Reasonable and Customary Charges for Out-of-Network Providers, the Network allowance for Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

(3) If the provider provides services under a Medicare Private Contract Option, the Allowable Fees will be based on the Usual, Reasonable and Customary Charges for Out-of-Network Providers or the Network allowance for Network Providers, for services covered by this Plan.

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Plan Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits Incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

While a Domestic Partner is not a Qualified Beneficiary under the federal COBRA regulations, the Bedford Central School District provides "COBRA-like" continuation coverage to a Domestic Partner who is covered under this Plan (similar to that of a Covered Spouse, as described below).

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees/Retirees and their families covered under the Bedford Central Schools Health Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Bedford Central School District, Fox Lane Campus, Mt. Kisco, New York 10549, telephone 914-241-6019. COBRA continuation coverage for the Plan is administered by POMCO, 2425 James St., Syracuse, New York 13206, 1-800-358-8399. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse/Domestic Partner of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse/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.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned

income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse/Domestic Partner or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. **A domestic partner is not a Qualified Beneficiary under the federal COBRA regulations, the Bedford Central School District provides "COBRA-like" continuation coverage to a Domestic Partner who is covered under this Plan, similar to that of a Covered Spouse.**

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse or if a Domestic Partnership no longer meets eligibility criteria of the Plan.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse/Domestic Partner or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA

continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse, termination of Eligible Domestic Partnership or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Bedford Central Schools District Office
Fox Lane Campus
Mt. Kisco, New York 10549

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost (if under your plan the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing

condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR.

Bedford Central Schools Health Benefit Plan is the benefit plan of Bedford Central School District, the Plan Administrator, also called the Plan Sponsor.

An individual may be appointed by the Bedford Central School District to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Bedford Central School District shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION.

The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Enrollees.

The level of any Enrollee contributions will be set by the Plan Administrator. These Enrollee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Enrollee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

HIPAA COMPLIANCE

The federal Health Insurance and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Employee covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Covered Person. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's Privacy Officer at the Employer.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees and Retired Employees. The Plan is not insured.

PLAN NAME

Bedford Central Schools Health Benefit Plan

TAX ID NUMBER

136012148

PLAN EFFECTIVE DATE

January 1, 1999

PLAN YEAR ENDS

December 31

RESTATEMENT DATE

January 1, 2011

EMPLOYER INFORMATION

Bedford Central Schools District, P.O. Box 180, Fox Lane Campus, Mt. Kisco, NY 10549, Tel. #: 914-241-6019

PLAN ADMINISTRATOR

Bedford Central Schools District, P.O. Box 180, Fox Lane Campus, Mt. Kisco, NY 10549,Tel. #: 914-241-6019

CLAIMS ADMINISTRATORS

Medical Benefits
POMCO
2425 James Street
Syracuse, New York 13206
1-800-358-8399

Prescription Drug Benefits
CVS/Caremark
620 Epsilon Drive
Pittsburgh, PA 15238
1-888-645-9303