Master Plan Document
and
Summary Plan Description
For

Syracuse City School District Health Benefits Plan
(A self-funded benefit plan for Employees and Retirees of SCSD)

RESTATED JULY 1, 2006
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Syracuse City School District Health Benefits Plan

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INTRODUCTION

This Master Plan Document (also shown hereafter as MPD) shows coverage for the self-funded Syracuse City School District Health Benefits Plan (also shown hereafter as Plan). The preventive care, hospital, major medical and prescription drug expense benefits shown in this Plan are available for eligible SCSD Employees, retirees and their Eligible Dependents. SCSD has designed a Plan that provides health benefits for a broad range of medical services at the lowest possible cost. A number of features have been included in this Plan to manage costs and to ensure that the health care benefits are within Plan guidelines.

Plan Identification

Plan Name: Syracuse City School District Health Benefits Plan
Plan Sponsor: Syracuse City School District
Plan Administrator: Syracuse City School District
Plan Effective Date: May 1, 1993
Plan Year: January 1 through December 31
Plan Restatement Date: July 1, 2006
Claim Administrators:
   Medical Benefits: POMCO, Inc.
   Benefit Management: POMCO, Inc.
   Prescription Benefits: SCSD Pharmacy Benefit Manager for Network Pharmacy and Mail Service Prescription Benefits
                      POMCO, Inc. for out of network pharmacy or secondary payer benefits.

Please Note

This MPD clarifies, updates and replaces previous Plan documents or other publications concerning coverage and benefits for the self-funded Syracuse City School District Health Benefits Plan. It is a restatement of Plan benefits in effect as of July 1, 2006. The pronoun you or your means an eligible and enrolled Employee or retiree of the Syracuse City School District. It also means a survivor Spouse or COBRA participant whose Social Security number is used for Plan enrollment. Terms throughout this document have been capitalized and are defined in Appendix B - Definitions to help you understand your Plan Coverage and benefits.

The Plan Administrator, Syracuse City School District, provides a handbook to eligible and enrolled employees and retirees that shows the following description of the Plan. This handbook is not intended to interpret, extend, or change the provisions of the Plan in any way. The provisions of this Plan may only be determined accurately by reading the Master Plan Document, Amendments and other documents concerning the terms of the Plan. To the extent the employees’ handbook or other Plan information is inconsistent with the provisions of the Master Plan Document, the terms of the Master Plan Document will govern. The Master Plan Document, the terms of the Plan and any Amendments to the Plan, is maintained and on file with the Plan Administrator.

Plan benefits are self-funded and paid by the Syracuse City School District. POMCO has been engaged by the District to act as the Claims Administrator on the District's behalf and to administer the Benefits Management Program.

1. Medical Benefits. POMCO administers claims for the Participating Provider, Preventive Care, Hospital, Medical/Surgical and Major Medical Expense Benefits. Claims should be mailed directly to POMCO for benefit determination. If you have any questions or concerns about your Coverage, you can phone the Syracuse School District or the SCSD claims unit at POMCO. Claim forms can be obtained from your Benefits Office or from POMCO. Refer to Section VII-Claim Submission and Review Procedures for details on how to submit a claim.

   POMCO
   P.O. Box 6329
   Syracuse, NY 13217-6329
   Local: (315) 432-5567 or Toll-free: 1 800 358-8399
2. **Benefit Management Program Administrator.** POMCO administers the Benefit Management Program. You are required to phone the POMCO Managed Care Unit to meet requirements of the Benefits Management Program. Failure to comply with the requirements of this program could result in reduction of your benefits. Refer to **Section III - Benefit Management Program** for full details of program requirements. Mandatory phone calls are required. You must call POMCO:

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

   **Phone:** POMCO Managed Care Unit Local (315) 432-5567 or Toll Free: 1-800-358-8399
   This is a 24-hour service. If you wish to talk to the POMCO nurses, you must call between 8:30 a.m. and 4:30 p.m. on normal business days. Otherwise give complete information as requested by voice mail message.

3. **Network Pharmacy.** *If this Plan is primary payer for prescription drug benefits*, the SCSD Pharmacy Benefit Manager administers claims for Network pharmacy benefits. (If this Plan is secondary payer, claims must be submitted to POMCO with copy of other Plan payment). Mandatory generic substitution and Copayments apply. Long term or maintenance drugs must be obtained through the mail service pharmacy. Refer to **Appendix A** that describes the SCSD Pharmacy Benefit Manager’s Prescription Expense Benefits for details on how to obtain benefits.

4. **Mail Service Prescription Benefits.** *If this Plan is primary payer for prescription drug benefits*, the SCSD Pharmacy Benefit Manager administers the mail service program for maintenance drugs. This program is not available if this Plan is secondary payer for your prescription drugs. Refer to Appendix A that describes the SCSD Pharmacy Benefit Manager’s Prescription Expense Benefits for details on how to obtain benefits.
SECTION I - SUMMARY OF BENEFITS

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

Please Note
All claims are subject to review to determine whether or not services are Covered in accordance with plan limitations. You must comply with requests for additional medical documentation as deemed necessary to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. Treatment decisions are independent from payment decisions. The patient's Physician is responsible for determining whether treatment should be rendered regardless of whether the charges are totally or partially included in, or excluded from, Coverage under this Plan.

A. Summary

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

1. Network and Out of Network Expenses. Network means services and supplies rendered and billed by the POMCO Plus/Allied Network (Network) Participating Providers (Network Providers). Out of Network means services and supplies rendered and billed by Nonparticipating Providers. You or your Dependents may choose either for medical care. However, the Network Providers have an agreement with POMCO to bill according to an established fee schedule. Usually, these fees result in savings for both you and the Plan. Please refer to Section IV - Covered Services under Participating Provider Network Program for details.

2. Full Benefits. The terms Full Benefits or Full Network Benefits mean 100% of Allowable Fees.

3. Allowable Fees.
   a. Out of Network Providers. Allowable Fees mean the Usual, Customary and Reasonable (UCR) Charges, as decided by the Claims Administrator, for Covered medical services or supplies rendered and billed by a Covered nonparticipating or out of Network Provider. The services or supplies must be incurred by a Covered Person while eligible for Plan Coverage. If you or your Eligible Dependents use an out of Network Provider, you will be responsible for the payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance, if any, plus applicable Plan Deductibles and percentage Copayment amounts. Out of Network means services or supplies rendered by a Provider who does not have an agreement with the Participating Provider network.
   b. Network Participating Providers. Allowable Fees mean the scheduled network allowance for Covered medical services or supplies rendered and billed by Providers who participate in the POMCO Allied Network, a national network of Participating Providers. The services or supplies must be incurred by the Covered Person while eligible for Plan Coverage. The Network Provider has an agreement with the Claims Administrator to bill for Covered Services and Supplies according to the Network schedule of allowances. Usually, this allowance is considered payment in full.

Please Note
You may call POMCO for information on Providers near you. You may also access the directory of Participating Providers on the POMCO website: www.pomcoplus.com.

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

Network Benefits are not available if this Plan is secondary payer according to the Coordination of Benefits Rules shown later in this document. If this Plan is secondary to another health plan except Medicare, usual Plan Deductibles and percentage Copayments will apply whether or not a participating or Network Provider is used. You will be responsible for the payment of charges more than the Usual, Customary and Reasonable (UCR) allowance plus applicable Plan Deductible and percentage Copayments. Network benefits are available if Medicare is the only primary Coverage. In this case, the Plan waives the Network Copayments.

4. **Free Choice of Providers.** You or your Dependents may seek medical care from any Network or Out of Network Health Care Provider. This Plan does not restrict specialist care to primary Physician referral. If a Covered Person seeks treatment from a Physician specialist, Covered Expenses will be considered even if not referred by a primary or family Physician. This Plan does not require that you use a member Hospital for your care. The Plan does not impose any emergency conditions to your choice of Providers. Although the Plan does not restrict your choice of Providers, the Plan allowance for Covered Expenses will be based on your choice of either Network Providers or Out-of-Network Providers.

5. **Maternity Care.** Maternity or pregnancy care is Covered the same as any other illness including but not limited to childbirth, miscarriage, legal elective/voluntary abortions and other termination of Pregnancy. The Plan excludes services and supplies related to surrogate pregnancies.

**Federal Newborns’ and Mothers’ Health Protection Act of 1996.** This notice is mandated by requirement of the Public Service Health Act, a Federal law. Group health plans and health insurance issuers 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 Insurers may not, under Federal law, require that a Provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

6. **Federal Mastectomy Notice.** This notice is mandated by requirements of the Public Service Health Act, a federal Law. The description of Coverage shown below is not a change in Plan benefits. This Plan Covered these services before this law was passed.

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

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

**Note:** All benefits for Covered Services are based on Allowable Fees. When using a Network Provider you need only pay applicable Copayments. If you use an Out of Network Provider, you are responsible for payment of applicable Deductible and any charges more than the Usual, Customary and Reasonable (UCR) allowance. Some services are only Covered when obtained from a Network Provider and will not be paid if obtained from an Out of Network Provider. These services will be so noted.

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<th>Preventive Covered Services</th>
<th>Network</th>
<th>Out of Network</th>
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<tr>
<td>IV B 1</td>
<td>Well Child Care <strong>Benefits are provided for eligible children from birth through age 18. Includes age appropriate well child care, usual related tests and immunizations. Out of Network Benefits count toward Major Medical Calendar Year/Lifetime Benefit Limits.</strong></td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charges, after Deductible</td>
</tr>
<tr>
<td>IV B 4</td>
<td>Routine Physician Nursery Care</td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible</td>
</tr>
<tr>
<td></td>
<td>Well Child Care</td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible</td>
</tr>
<tr>
<td></td>
<td>Adult Routine or Well Care <strong>Benefits are provided for limited routine care services (preventive) not due to Illness or Injury.</strong></td>
<td>Full Network Benefits up to benefit maximum $50.00 once per Calendar Year for exam only any combination of Network and Out of Network Providers. Network Provider may balance bill up to Network allowance. Related diagnostic tests are Covered separately.</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible, up to benefit maximum of $50.00 once per Calendar Year for exam only any combination of Network and Out of Network Providers. Related diagnostic tests are Covered separately.</td>
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<td>IV B 3</td>
<td>Adult Physical Exam (Limited to active Employees age 50 or older, not payable for any other Covered Persons)</td>
<td>$15.00 Copayment for Outpatient Hospital services. Current Copayment for other Providers.</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible</td>
</tr>
<tr>
<td>IV B 2</td>
<td>Routine Mammography (age 18 or older, Coverage frequency based on age and medical history.)</td>
<td>Full Network Benefits for exam only any combination of Network and Out of Network Providers. Network Provider may balance bill up to Network allowance. Related diagnostic tests are Covered separately.</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible, up to benefit maximum of $50.00 once per Calendar Year for exam only any combination of Network and Out of Network Providers. Related diagnostic tests are Covered separately.</td>
</tr>
<tr>
<td>IV B 1</td>
<td>Annual Pap Test and Related Gyn Exam. (Female age 18 or older)</td>
<td><strong>Note:</strong> This exam may be substituted for a well child physical for females under age 18.</td>
<td>Not a Benefit</td>
</tr>
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<td>IV B 4</td>
<td>Routine Colonoscopy</td>
<td>50% of the network allowance</td>
<td>50% of Usual, Customary and Reasonable Charges (UCR), after Deductible</td>
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<td><strong>Limited to one screening every 10 years for Covered Persons aged 55-64 years. Maximum benefit - $500.00.</strong></td>
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### C. Hospital Expense Benefits (HEB)

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<th>HEB Covered Services</th>
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<tr>
<td>IV C</td>
<td>Hospitals, Other Facilities and Agencies</td>
<td><em>Most Inpatient admissions and home health care require a mandatory phone call to the Claims Administrator.</em> See Section III - Benefits Management Program for details.</td>
</tr>
<tr>
<td></td>
<td>Benefits are provided for services and supplies rendered and billed by a Covered Hospital, facility or agency for the treatment of an Illness or Injury. Inpatient private room will be allowed at the Average Semi-Private Rates, unless shown otherwise. Private duty nursing and Physicians charges are Covered separately.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit limits are per Covered Person and are cumulative for In Network and Out of Network Providers. <strong>Note:</strong> If you use an out of Network Provider you could be responsible for payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance.</td>
<td></td>
</tr>
<tr>
<td>IV C 1a</td>
<td>Acute Care General Hospital</td>
<td>Full Benefits for 365 benefit days per Spell of Illness. Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. Date of discharge is not allowable. Additional Coverage is available under Major Medical Expense Benefits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
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<tr>
<td></td>
<td>Medical/Surgical, Maternity</td>
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<tr>
<td></td>
<td>Mental Illness Inpatient Limits</td>
<td>Full Benefits up to 120 benefit days per Calendar Year when approved through the Benefits Management Program. Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. In no event will the Plan pay more than 120 days per Calendar Year for any combination of Inpatient stays in an Acute Care General Hospital or Psychiatric Facility. Additional Coverage is not available under Major Medical Expense Benefits.</td>
</tr>
<tr>
<td>IV C 1b</td>
<td>Outpatient</td>
<td>Hospital Outpatient Copayment applies. Enrollee must pay Copayment amount, if any, then Plan pays balance of Allowable Fees. Limited to 12 Copayments per Calendar Year per Covered Person.</td>
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<td>Accidental Injury</td>
<td>$35.00 Copayment Services must be within 72 hours of accident. Copayment is waived if patient is admitted to the same Hospital from the Outpatient department.</td>
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<td>Sudden Serious Illness</td>
<td>$35.00 Copayment Services must be rendered within 12 hours from onset of acute symptoms. Copayment is waived if patient is admitted to the same Hospital from the Outpatient department.</td>
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<tr>
<td></td>
<td>Surgery</td>
<td>$15.00 Copayment. Copayment is waived if patient admitted to the same Hospital from the Outpatient department.</td>
</tr>
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<td></td>
<td>Radiation or X-ray Therapy</td>
<td>Full Benefits.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic X-ray/ Lab/Tests</td>
<td>$15.00 Copayment. Copayment is waived when patient is admitted to the same Hospital from the Outpatient department.</td>
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<td>Preadmission Testing</td>
<td>$15.00 Copayment. Patient must be present for testing rendered within 7 days before Surgery.</td>
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<tr>
<td>Section</td>
<td>HEB Covered Services</td>
<td>Network Benefits and Out-of Network Benefits</td>
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<td></td>
<td>Physical Therapy</td>
<td>Full Benefits in connection with related Hospitalization for therapy commencing within 6 months and rendered within 365 days from Hospital discharge date. Other Physical Therapy care rendered in the Outpatient department is considered under Major Medical Expense Benefits.</td>
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<td>Inhalation Therapy</td>
<td>Full Benefits.</td>
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<td></td>
<td>Other Outpatient Services</td>
<td>Coverage available under Major Medical Expense Benefits.</td>
</tr>
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<td>IV C 2</td>
<td>Ambulatory Surgical Facility</td>
<td>Full Benefits for Covered surgical procedures. Physician charges are Covered separately.</td>
</tr>
<tr>
<td>IV C 3</td>
<td>Birth Center</td>
<td>Full Benefits for birthing room or Inpatient Care. Benefits paid on same basis as acute care Hospital.</td>
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| IV C 7  | Psychiatric Facility | Coverage is limited to 90 benefit days per Calendar Year for any combination of stays in private or government-owned psychiatric facilities. Stays in an Acute Care General Hospital are Covered separately. Benefit days count toward the 120-day limit for Acute Care General Hospital.  
  **Private Facility Inpatient** | Full Benefits when approved through the Benefit Management Program. Additional Coverage is not available under Major Medical Expense Benefits.  
  **Government Owned Facility** | Full Benefits when rendered in an emergency/crisis situation, holiday, or weekend. The Major Medical Deductible applies if Covered Person remains in the facility once the condition is stabilized and a bed becomes available in an acute care hospital or private psychiatric facility.  
  **Acute Care General Hospital** | Please see Acute Care General Hospital, Mental Health Inpatient Limits. |
| IV C 4  | Skilled Nursing Facility Inpatient | Full Benefits. Each day equals 1/2 benefit day. Semi-private room limit. Benefit days count towards the Hospital 365 day per Spell of Illness limit. Additional Coverage is not available under Major Medical Expense Benefits. If Medicare is primary payer, benefits are not payable.  
  **Outpatient** | Coverage available under Major Medical Expense Benefits. |
| IV C 8  | Alcohol/Substance Abuse Facility Inpatient | Full Benefits. Limited to 30 days per confinement, per Calendar Year and 60 days per lifetime for each Covered Person. Services and Plan of Care must be approved through the Managed Care Program. Semi-private room limit. Additional benefits are not available under Major Medical Expense Benefits.  
  **Outpatient** | Benefits are available for an Approved Plan of Care for Outpatient services by a certified alcohol or certified Substance Abuse Facility for the diagnosis and treatment of alcoholism or substance abuse. 60 benefit days per Calendar Year and up to 180 benefit days per lifetime. 20 of the 60 visits may be used for the affected person’s Covered family members. |
| IV C 5  | Home Health Care Agency | Full Benefits for Approved Plan of Care for each visit day. Maximum 40 visits per Calendar Year. |
D. Medical/Surgical Expense Benefits

If you use a Network Provider, Network Copayment could apply. Enrollee must pay Copayment amount, if any, then Plan pays balance of Allowable Fees. Copayment limit is per Covered Person per event. Per event means Medical Surgical Expense and Major Medical Expense Covered Services rendered and billed by the same Network Provider on the same day. Network Copayment does not apply if Medicare pays primary benefits. **Note: If you use an Out of Network Provider you could be responsible for payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance (balance of bill).**

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical/Surgical Covered Services</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV D1</td>
<td><strong>Surgeon</strong></td>
<td>Full Network Benefits for Inpatient Surgery. Current Copayment for Outpatient Surgery (office, Hospital or ambulatory facility).</td>
<td>100% of Usual, Customary, and Reasonable Charges (UCR)</td>
</tr>
<tr>
<td></td>
<td><strong>Assistant Surgeon</strong></td>
<td>Full Network Benefits</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges</td>
</tr>
<tr>
<td>IV D2</td>
<td><strong>Anesthesia</strong></td>
<td>Full Network Benefits</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges for administration during Covered Surgery. Other Covered anesthesia administration Covered under Major Medical Expense Benefits.</td>
</tr>
<tr>
<td>IV D3</td>
<td><strong>Inpatient Physician Visits</strong></td>
<td>Full Network Benefits. See separate limit for Mental Illness care.</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges up to one visit per day for attending Physician. Limit 120 days per Spell of Illness. See separate limit for Mental Illness care.</td>
</tr>
<tr>
<td></td>
<td><strong>Attending Physician</strong></td>
<td>Full Network Benefits</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges for one visit per day per specialty. Counts toward 120-day limit.</td>
</tr>
<tr>
<td></td>
<td><strong>Two or More Physicians</strong></td>
<td>Full Network Benefits</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges for critical constant care up to maximum of 5 hours per day. Counts toward 120-day limit.</td>
</tr>
<tr>
<td></td>
<td><strong>Special Visits</strong></td>
<td>Full Network Benefits</td>
<td>100% of Usual, Customary, and Reasonable (UCR) Charges for critical constant care up to maximum of 5 hours per day. Counts toward 120-day limit.</td>
</tr>
</tbody>
</table>
### IV D4

**Mental Illness Visits**

*Coverage for visits is limited to the number of inpatient days approved for benefits through the Benefits Management Program. In no event will the Plan pay more than 120 visits per Calendar Year for any combination of acute care General Hospital or private facility stays.*

Full Benefits limited to one visit per day up to 120 visits per Calendar Year in acute care General Hospital, 90 visits in private Psychiatric Facility. Additional Coverage is not available under Major Medical Expense Benefits.

### IV D3

**Specialist Consultations**

**Full Network Benefits**

100% of Usual, Customary, and Reasonable (UCR) Charges

### IV D5

**Second Surgical Opinion**

**Full Network Benefits**

100% of Usual, Customary, and Reasonable (UCR) Charges

### IV D6

**Radiation or X-ray Therapy**

**Full Network Benefits**

100% of Usual, Customary, and Reasonable (UCR) Charges

### IV D7-8

**Diagnostic X-rays, Lab, Pathology and Machine Tests**

Current Copayment for single or series of diagnostic procedures.

100% of Usual, Customary, and Reasonable (UCR) Charges

### IV D9

**Emergency Physician Care**

**Full Network Benefits.**

100% of Usual, Customary, and Reasonable (UCR) Charges

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### E. Major Medical Expense Benefits

**Deductibles, Copayments and Benefit Maximum:** Unless shown otherwise, the Plan Deductibles and percentage Copayments apply to Out of Network Allowable Fees. The Network Copayments apply only when shown for Covered Network services.

- **Calendar Year Deductible:** The part of the Allowable Fees that the participant must pay each Calendar Year. Benefits are based on the balance.
- **Percentage Copayment:** The portion of Allowable Fees paid by the Plan (usually after Deductible is taken).
- **Network Copayment:** The portion of the Network allowable fee paid by the Employee or retiree. This Copayment does not count toward Major Medical Deductibles or Percentage Copayments. Per Event: Means all services rendered by the same Provider on the same day.

**Calendar Year/Lifetime Benefit Maximum:** The most the Plan will pay per Covered Person for Major Medical Expense Benefits. Except as shown otherwise, all Covered Expenses are subject to the Major Medical Calendar Year Deductible, Copayment limits, and lifetime benefit maximum.

<table>
<thead>
<tr>
<th>Major Medical Expenses</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>Does not apply</td>
<td><strong>Per Individual:</strong> $ 75.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Family Limit:</strong> $225.00 for three or more family members.</td>
</tr>
<tr>
<td><strong>Common Accident Deductible</strong></td>
<td>Does not apply</td>
<td>$75.00 each Accident.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
### Major Medical Expenses

<table>
<thead>
<tr>
<th>Major Medical Expenses</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage Copayment</strong></td>
<td>Does not apply</td>
<td>After Deductible, Plan pays 80%. <strong>Percentage Copayment Limit:</strong> After the Deductible, Plan pays 80% of the first $2000.00 of Allowable Fees, then pays 100% of the balance for the remainder of the Calendar Year per Covered family. (Your out of pocket is $400.00 (20% of $2000.00)).</td>
</tr>
<tr>
<td><strong>Network Copayment</strong></td>
<td>Current Copayment per Covered Person per Event. <strong>Does not apply when Medicare pays primary benefits.</strong></td>
<td>Does not apply.</td>
</tr>
<tr>
<td><strong>Lifetime Benefit Maximum</strong></td>
<td>Does not apply.</td>
<td>$1,000,000.00 actual Major Medical Benefits per each Covered Person.</td>
</tr>
</tbody>
</table>

**Note:** If you use an Out of Network Provider you could be responsible for payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance. After Network Copayments Plan usually pays balance of Network allowance in full. However, if the Plan limits payment on the Network allowance to a percentage, number of visits, Calendar Year benefit or similar limit, the Network Provider could balance bill up to the Network scheduled or negotiated allowance.

<table>
<thead>
<tr>
<th>Section</th>
<th>Major Medical Covered Services</th>
<th>Network Benefits</th>
<th>Out of Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV E 6</td>
<td>Acute Care General Hospital Outpatient Physical Therapy</td>
<td>Current Copayment per event</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible</td>
</tr>
<tr>
<td>IV E 1</td>
<td>Acute Care General Hospital Outpatient and Inpatient</td>
<td>80%, after Deductible, for Covered Services after Hospital Expense Benefits exhausted. In Network and Out of Network expenses count toward the percentage Copayment Limit. See separate benefit for Physical Therapy shown above.</td>
<td></td>
</tr>
<tr>
<td>IV E 2</td>
<td>Office Visits and Therapy</td>
<td>Current Copayment per event</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible</td>
</tr>
<tr>
<td>IV E 2</td>
<td>Allergy Injections</td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible</td>
</tr>
<tr>
<td>IV E 13</td>
<td>Kidney Dialysis Procedures</td>
<td>Full Network Benefits (Office evaluation and management visits subject to Current Copayment.)</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible</td>
</tr>
<tr>
<td>IV E 12</td>
<td>Chemotherapy Procedures</td>
<td>Full Network Benefits (Office evaluation and management visits subject to Current Copayment.)</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible</td>
</tr>
<tr>
<td>Section</td>
<td>Major Medical Covered Services</td>
<td>Network Benefits</td>
<td>Out of Network Benefits</td>
</tr>
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<td>---------</td>
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</tr>
<tr>
<td>IV E 10</td>
<td>Outpatient Mental Illness</td>
<td>Current Copayment per visit. Limited to 30 visits per Calendar Year for any combination of Network and Out of Network Providers.</td>
<td>After Deductible, Plan pays 50% of Allowable Fees. Percentage Copayment limit does not apply. Limited to 30 visits per Calendar Year for any combination of Network and Out of Network Providers.</td>
</tr>
<tr>
<td>IV E 9</td>
<td>Hairpieces and Wigs</td>
<td>Full Network Benefits (Note: As of July 1, 2006, there are no network providers.)</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible up to maximum benefit of $500.00 for first wig or hairpiece, once per lifetime for hair loss following Covered chemotherapy.</td>
</tr>
<tr>
<td>IV E</td>
<td>Other Major Medical Expenses</td>
<td>Full Network Benefits</td>
<td>Allowable Fees are subject to Major Medical Calendar Year Deductible, percentage Copayment limits, and lifetime maximums.</td>
</tr>
</tbody>
</table>

G. Potential Causes for Benefit Reduction

   
   You or your Dependent should enroll for Medicare upon eligibility or when Medicare is considered primary coverage. Failure to enroll in Medicare when Medicare is primary could result in significant reduction or denial of your health benefits. You could be responsible for the payment of all or most of your health expenses.
   
   Medicare payments could reduce your benefits if Medicare is considered the primary coverage according to Medicare Secondary Payer rules. This reduction will apply whether or not the person eligible for Medicare is actually enrolled in Medicare. Refer to Section V - Medicare Integration with Plan Benefits.

2. Coordination of Benefits Effect on Plan Benefits. Your benefits could be reduced if you or your Eligible Dependents are Covered by more than one health plan. Refer to Section VI - Coordination of Benefits.

3. Benefit Management Program. Your benefits could be reduced if you fail to follow the requirements of the Benefit Management Program. Refer to Section III - Benefit Management Program.
SECTION II - ELIGIBILITY AND ENROLLMENT

A. Eligibility for Plan Enrollment

1. Active Employees

The SCSD Benefits Office can provide details concerning your eligibility requirements for Plan enrollment. Eligibility rules can vary subject to union negotiated settlements or SCSD policy change. The following are general rules for enrollment eligibility.

To be eligible for Plan enrollment, Employees must have been hired for an anticipated Full-time employment period of at least three months to be eligible for Plan enrollment. Other requirements for eligibility are based on your bargaining unit’s contract with SCSD.

Please Note

Even though the above requirements may be met, any unenrolled Employee who submits an initial enrollment application while temporarily removed from the payroll (i.e. lay-off or Leave of Absence) will not be eligible for Plan Coverage until after he or she is once more on the SCSD payroll.

2. Retirees. To be eligible for Plan enrollment, retired Employees must be considered a retiree in accordance with the following employer's retirement eligibility requirements for Coverage under this Plan:

a. A retiree who was not a member of the District Health Benefits Plan while an active Employee is not eligible to join the program after the date of retirement.

b. A person hired prior to January 1, 1980, who retires at age 55, must have at least 5 years of Full-time service in the City School District to be eligible for full participation in the City School District Plan. The retiree must contribute to the cost of benefits, an amount equal to the current cost of Medicare Part B. If the Spouse is elected to be Covered also, the cost will be twice that amount. This amount will change annually on January 1. Payment is made directly to the Health Benefits Office on a 6-month billing. When a retiree or Spouse reaches age 65, all payments are paid by the District. The retiree is responsible for paying Medicare B coverage directly to the Federal Government.

c. A person hired after January 1, 1980, who retires at age 55, must have at least 10 years of Full-time service in the City School District to be eligible for full participation in the City School District Plan. The retiree must contribute to the cost of benefits, an amount equal to the current cost of Medicare Part B. If the Spouse is elected to be Covered also, the cost will be twice that amount. This amount will change annually on January 1. Payment is made directly to the SCSD Benefits Office on a 6-month billing. When a retiree or Spouse reaches age 65, all costs are paid by the District. The retiree is responsible for paying Medicare B coverage directly to the Federal Government.

d. A person hired after January 1, 1980, who retires at age 65, must have at least 10 years of Full-time service in the City School District to be eligible for full participation in the City School District Plan. All costs are paid by the District. The retiree is responsible for paying Medicare B coverage directly to the Federal Government.

e. A person with New York State vested rights (at least 10 years of service) who leaves the District between ages 50 and 55 can remain in the Plan if they pay 100% of the cost. If the person leaves the program at any time during this period, they cannot be reinstated. If the person remains until age 55, they are then continued in the Plan under the same conditions as someone who retires at age 55.

f. A retiree may not change benefits from single to family after the date of retirement; however, they may change from family to single Coverage.

g. A person under the age of 55, who receives disability retirement benefits, has the same rights as a regular retiree.

h. A person under the age of 55 who retires under a special retirement incentive program offered by the State of New York and approved by the SCSD Board of Education has the same rights as a regular retiree.

i. If a retiree has acquired, or in the future becomes eligible to acquire, health benefits from another employer, the retiree must enroll either as a dependent or an Employee in the other employer's plan.
j. A Dependent survivor may continue in the plan if the deceased Employee or retiree had at least 10 years of service. The survivor is responsible for payment of 100% of the cost beginning the first day of the third month following the death. A separate enrollment is necessary.

3. Dependents.

The SCSD Benefits Office may require documentation of the Dependent status. Criteria of support will be deemed to have been met if the Employee or retiree contributes at least 50 percent to the support of the Dependent and that Dependent qualifies as an exemption on a current Federal income tax return filed by the Employee or retiree.

The following Dependents are eligible to be enrolled under an Employee or retiree’s family Coverage:

a. Legal Spouse of the Employee or retiree. (a legally separated Spouse may be enrolled in the Plan, but a divorced Spouse is not eligible).

b. Unmarried Children of the Employee or retiree who are:

1) Under 19 years of age. Your newborn child is eligible from the date of birth if enrolled in family Coverage within 30 days after the date of birth.

2) Over 19 years of age but under 25 who receive more than half of their support from the Employee or retiree and who are enrolled as full-time students and attending an accredited secondary College or University; school or institution of learning. Full-time status is defined by the College, University, school or institution; graduate-level students on internships are considered to be full-time students if the institution validates full-time status. 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.

Your unmarried Dependent child, between the ages of 19 and 25, for purposes of eligibility, shall be considered to still be a student for a period of 120 days prior or subsequent to graduation from, entrance to or enrollment/re-enrollment in high school or a College or University providing the student meets all other eligibility requirements.

Your Unmarried Dependent child, between the ages of 19 and 25 who is a full-time student becomes unable to attend school due to a disability that starts after age 19 could maintain student eligibility. To be eligible for this extension, medical certification must be submitted to the SCSD Benefits Office. This certification must show the child to be incapable of self-support by reason of permanent or long-term mental or physical disability that started after age 19. The eligibility should be established as early as possible following the start of the disability. If approved, the Dependent will continue to eligible for student Coverage until the date the disability ends or until age 25 (limiting age for student eligibility), whichever occurs first. If the disability ends and the child returns to full-time student status before age 25, the Dependent's student eligibility will be extended beyond his or her 25th birthday for the exact length of the former disability.

Your unmarried Dependent child between the ages of 19 and 25 who previously was not eligible for benefits or had benefits terminated and who returns to a full-time student status, 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, providing the student meets all other eligibility requirements.

Please Note
Eligibility for child attending school as a full time student will terminate at 12:01 a.m. on the date of his/her 25th birthday or the date at the end of student extension after disability. When eligibility ends, the child could qualify for Continuation of Coverage under COBRA shown later in this section.

3) Age 19 years or older who is incapable of self-support by reason of permanent or long term Mental or physical disability and who became so disabled before reaching age 19. The eligibility of such a Dependent should be established as early as possible. This should be done at the time of your initial
enrollment. If your Dependent enrolled child, under age 19, becomes disabled and incapable of self-support after the time of your initial enrollment, you should advise the SCSD Benefits Office immediately. Eligibility must again be established at the time of his or her 19th birthday.

<table>
<thead>
<tr>
<th>Please Note</th>
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<tbody>
<tr>
<td>To obtain Plan Coverage for disabled Dependents or full-time students, you will be required to document, at least annually, appropriate certification of this fact. Failure to provide the Syracuse City School District with this information when requested will result in that particular Dependent child being removed from enrollment and eligibility for benefits under the Benefits Plan until proof is provided supporting continued eligibility under the Benefits Plan.</td>
</tr>
</tbody>
</table>

4) If age 19 years or older but under age 25 and attending an accredited College or University on a full-time basis prior to the disability with the intention to resume full-time enrollment after the disability ends, eligibility will continue pending medical certification.

c. Child Definition - Child or children means:

1) The Employee or retiree's own child or legally adopted child, whatever the child's place of residence or support provided;
2) Any stepchild of the Employee or retiree who permanently resides in the Employee or retiree's home.
3) Any other child supported by the Employee or retiree or the Spouse of the Employee or retiree and permanently residing in the Employee or retiree's home, provided the support and residence commenced before the child reached age 19; or
4) Any unmarried child placed for adoption before the child reaches age 18. The term placed for adoption means a child placed in the Employee or retiree’s home and the Employee or retiree’s assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. This eligibility ends when such legal obligation terminates. Proof of preadoption status will be required by the SCSD Benefits Office to establish eligibility. Once the child is legally adopted, he or she retains eligibility as a legally adopted child as shown above.

5) Pre-adoptive newborn from the moment of birth under a family Plan when all of the following conditions are met:
   a) You enroll the child that you intend to adopt in a family Plan within 30 days of the birth and applicable family Contribution is made, if any;
   b) You take physical custody of the child upon discharge from the Hospital or Birthing Center; and
   c) Within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under New York State Domestic Relations Law.

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

4. Other Eligibility. The SCSD Benefits Office can answer questions concerning eligibility and costs for continuation of Coverage while on disability leave or other Leave of Absence and the rules and costs for survivor Spouse continuation.

a. Disabled Employee. Employees receiving SCSD workers' compensation disability are required to pay the Employee's Plan Participation Contribution during an approved Leave of Absence if he/she wants to continue Coverage under the Plan. An Employee injured on the job may apply for waiver of Participation Contributions. See Waiver of Participation Contribution later in this section.

Employees who are on approved sick leave for Total Disability resulting from Non-occupational Sickness or Injury may apply for Waiver of Contribution. This waiver of contribution would be available only if you run
out of sick leave time. Eligibility would continue while you remain totally disabled for a maximum of one year without payment of Participation Contributions. See Waiver of Participation Contribution later in this section.

b. Surviving Spouse. A surviving Spouse of a vested Employee or eligible retiree with 10 or more years of service with the Syracuse City School District is considered eligible for continued enrollment in this Plan. However, direct continued payment of a designated Contribution is needed to maintain continued Coverage. If the surviving Spouse decides not to retain Coverage at the time of the Employee or retiree’s death, he or she cannot enroll at a later date. If the Spouse remarries, eligibility would end.

c. Leave of Absence.

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

2) Other Leave of Absence. You may retain eligibility for yourself and your Dependents when on an SCSD authorized Leave of Absence without pay that is more than the FMLA 12 weeks or for leaves not provided under the FMLA. However, you must remit the premium equivalent of both your share and the employer's share of the Plan Contribution amount directly to your employer. Upon returning to work, the Employee must pay 100% of the first month's cost. If benefits are dropped while on the Leave of Absence, a person cannot be reinstated to the Plan until returned to the payroll. A person has 30 days to re-enroll following their return to the payroll to receive a first day of the next month Effective Date. Persons failing to re-enroll will be considered late Enrollees with benefits effective the first day of the third month following the date of application. The person may receive immediate benefits by paying 102% of the premium equivalent each month when there are no benefits in effect. Any benefits used under a Leave of Absence will be subtracted from the COBRA maximum Contribution period if the person does not return to the payroll at the end of the authorized Leave of Absence.

3) Temporary Military Service. See Section F. Continuing Coverage under USERRA.

d. Qualified Medical Child Support Orders. Federal Law requires the SCSD, under certain circumstances, to provide Plan coverage for your children when you or your Spouse divorce or separate. The law also provides for children born out of wedlock. The SCSD must comply with a National Medical Support Notice as a qualified medical child support order (QMCSO) that relates to Plan benefits. QMCSO means orders, judgment, settlement, or a decree issued from a court of competent jurisdiction, magistrates or other officials with the power to issue a QMCSO pursuant to a state’s domestic laws, that requires an employer to provide available health plan coverage for your child. This coverage is provided even if you no longer have custody and even if you would not have chosen to cover the child under the existing health Plan. The child’s custodial parent, legal guardian or state agency can apply for coverage even if you don’t. If the Plan receives a QMCSO, it will provide immediate Plan enrollment. This means the child identified will be included for Plan coverage, as required according to the QMCSO requirements. You will be required to pay any new or added monthly participation costs for the child's enrollment. The SCSD Benefits Office will send you written notification and provide further information about the QMCSO rules should they receive an order that applies to you.

Please note
Any residence and support requirements are waived if you are required to provide health coverage due to a qualified medical support order for a child who is under age 19 and not living in your home.
B. Enrollment

The SCSD Benefits Office can provide the forms and instructions necessary to establish eligibility for Plan enrollment. No person may be eligible for enrollment both as an Employee/retiree and as a Dependent or as a Dependent of more than one Employee/retiree. Failure to report enrollment changes could result in overpayment of Plan benefits. Should this happen, SCSD or Claims Administrator could request that you reimburse the Plan for the overpayment. Failure to report enrollment changes on a timely basis could also result in longer Waiting Periods and delay the Effective Dates of Coverage.

Enrollment in the Plan is not automatic. You are required to enroll yourself and your Dependents. You must be Actively Employed or an eligible retiree to enroll in the Plan.

1. Individual Coverage. Only the Employee, retiree, survivor Spouse, or a COBRA participant is enrolled. Benefits will be paid only for the person enrolled even if other family members meet eligibility requirements.

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

3. Enrollment Changes. It is your responsibility to apply for any enrollment changes including:
   a. Adding a newly acquired Spouse or Dependent child;
   b. Adding an existing Spouse previously enrolled as an Employee or retiree;
   c. Adding a previously eligible but unenrolled Spouse or Dependent child;
   d. Changing from individual Coverage to family Coverage any time you acquire a Spouse or Dependent child or elect to enroll a previously eligible but unenrolled Spouse or Dependent child;
   e. Changing from family Coverage to individual Coverage when you no longer have Eligible Dependents or any time you no longer wish to provide Coverage for Eligible Dependents;
   f. Changing from two individual enrollments to one family Coverage or from one family Coverage to two individual enrollments when you or your Spouse are both eligible as an Employee or retiree under this health Plan;
   g. Changing or adding a new Dependent or removing an existing Dependent from family Coverage; or
   h. Reporting other group plan(s) and Medicare coverage information and changes.

C. Effective Dates of Coverage

You should consult with the SCSD Benefits Office to obtain specific information concerning how Effective Dates will be established for your or your Eligible Dependents. The following are general rules for Effective Dates of Coverage and 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 and enroll within 30 days.
   b. If an Employee enrolls within 30 days after the date of eligible employment, Plan Coverage begins no sooner than the first day of the month following the date SCSD accepts enrollment.
   c. If an Employee fails to enroll within 30 days from the start of eligible employment, Plan Coverage begins no sooner than the first day of the third month after the date SCSD accepts Plan enrollment. Exception: See Special Enrollment Effective Dates shown later in this section.
2. **Dependent General Rules.** Coverage for an Eligible Dependent will become effective on the date the Employee or retiree becomes Covered if the Employee or retiree applies for such Dependent Coverage when enrolling in the Plan. If the existing Dependent is not enrolled at the time of initial Employee or retiree enrollment, Coverage begins no sooner than the first day of the third month following the date SCSD accepts late Dependent enrollment. Exception: See *Special Enrollment Effective Dates* shown later in this section.

3. **Special Enrollment Effective Dates.**

   a. **Adding New Dependents.**

      1) If you are enrolled in the Plan and acquire new Dependents, after your initial enrollment, and enroll the new Dependents in family Coverage within 30 days after the date the Eligible Dependents are acquired, Plan Coverage for the new Dependent will begin on the date you acquired the Dependent, but no sooner than the Effective Date of your Coverage. You will be required to pay the family Plan participation payments, if any.

      2) If you are not enrolled in the Plan when you acquire a Spouse you may enroll yourself and your Spouse under family Coverage. If you acquire a newborn child, or a newly placed or adopted child (under Age 18), you may enroll yourself and/or your Spouse and the newly acquired newborn child, newly placed for adoption or adopted child under family Coverage. For Coverage to be effective on the date you acquired the new Dependent, you must enroll within 30 days after the date of marriage, birth, placement for or adoption, whichever applies. This immediate Coverage rule does not apply to children existing at the time of your initial eligibility.

      3) If you fail to enroll Eligible Dependents within 30 days from the date the Dependents were acquired, the new Dependents will be considered a late entrant. Coverage begins no sooner than the first day of the third month after the date SCSD accepts the late enrollment application.

   b. **Cancellation of Another Health Plan.** Eligible persons, who were not enrolled in this Plan due to other health plan coverage, may elect Coverage under this Plan. To be effective from the date the other coverage ended, the following conditions must be met:

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

If you fail to enroll yourself or Eligible Dependents within 30 days after involuntary cancellation of the other plan, Plan Coverage begins no sooner than the first day of the third month after the date SCSD accepts the late enrollment application. The late enrollment rule also applies to persons who voluntarily cancel the other plan then seek late enrollment in this Plan. Voluntary cancellation includes, but is not limited to, cancellation or withdrawal from the other coverage by the other plan enrollee; removal of Eligible Dependents from family coverage by the Enrollee; or cancellation of the other coverage due to enrollee fraud or enrollee nonpayment of required participation premiums or contributions.

**D. Plan Participation Contributions**

The SCSD Benefits Office can provide details concerning the costs for Plan participation under individual or family Coverage, survivor Spouse Coverage or while on Leave of Absence.

1. **Participation Contributions.** You and SCSD share the costs to administer and pay the benefits available under
the Plan. You must pay your designated share or Participation Contribution to these costs to maintain eligibility for Plan Coverage. This is usually done by payroll deduction. Contribution is usually based on a monthly premium equivalent for each Enrollee. If you fail to authorize the required payroll deductions, you could be refused Coverage under the Plan. Failure to remit required participation costs could end your Coverage. Coverage will stop at the end of the month for which the last required Participation Contribution was paid.

2. **Waiver of Participation Contribution (Active Employees).** If SCSD approves the waiver of contribution for active Employees who are disabled and unable to work, payment of participation costs will not be required for that Employee. To be eligible for this waiver as a disabled Employee, you must meet all of the following conditions:

   a. You must be totally disabled as a result of Sickness or Injury and must have been continuously so disabled for at least three months;
   b. You must be on an authorized Leave of Absence without pay; and
   c. You must have kept your benefits in effect by direct contribution payments to SCSD during any period you are off the payroll. An Employee on authorized leave without pay must remit both the Employee and the SCSD share of premium contributions.

The SCSD Benefits Office will assist you should you qualify for Waiver of Contribution. You will be required to complete the necessary forms and your Doctor will need to provide medical documentation to verify Total Disability. You may also be required to participate in an independent medical exam to confirm Total Disability.

If approved, the waiver will commence on the first day of the fourth month of your continuous disability or on the first day of the calendar month following exhaustion of accrued sick leave, whichever is later. To continue approved status, you may be requested to provide updated medical documentation from time to time or you may be required to participate in an independent medical exam to confirm continued Total Disability.

3. **End of Waiver**

   You must notify the SCSD Benefits Office should your status change for any of the reasons shown below. If benefits are paid for expenses incurred during a period when you are no longer eligible for this waiver, (or are not paying appropriate continuation participation costs) you could required to reimburse the Plan for the overpaid benefits.

This waiver will continue while you remain totally disabled due to Non-occupational Injury, but in no event for more than one year. Persons disabled due to SCSD occupational (on-the-job) Illness or Injury are eligible for the entire period of disability. If any of the following conditions occur before the expiration of the year, the waiver will cease regardless of whether disabled due to occupational or Non-occupational cause:

   a. Cessation of the disability;
   b. Your return to work or placement in a job with another employer;
   c. Approval of a request for retirement;
   d. Separation from service; or
   e. Your death.

E. **End of Coverage**

Plan Coverage ends for you and your Eligible Dependents when you no longer meet the eligibility requirement for Plan enrollment. Coverage for a Dependent ends when he or she no longer meets the Dependent eligibility requirements for Plan enrollment. If you are no longer eligible, your individual or family Coverage would terminate at 12:01 AM on the 1st or 16th day of the next month following the date of the last payroll period in which contributions for coverage were made. Examples: A person who made two payroll deductions for coverage in November would have Plan Coverage terminated at 12:01 AM on January 1. A person who made only one payroll deduction for coverage in November would have Plan Coverage terminated at 12:01 AM on December 16. Ten month Employees who leave the Syracuse School District after June 30 or fail to report for work in September will have their Plan Coverage terminated at 12:01 AM on September 1. If a Dependent is no longer eligible, Coverage ends at 12:01
A.M. on the date the child no longer meets eligibility requirements (i.e., child's marriage, reaches age limit, divorce of a Spouse). However, you or your Eligible Dependents could be eligible for Continuing Coverage under COBRA shown later in this section.

If you fail to make a required contribution, Coverage will terminate at the end of your prepaid Coverage period. Coverage may be stopped immediately if you or your Dependents knowingly submits a claim, or allows a claim to be submitted with false information, or conceals any facts, that could affect the outcome of a claim determination. In this case, you or your Dependents cannot continue Coverage under COBRA.

**F. Continuing Coverage Under USERRA**

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

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 18 month period beginning on the date on which the person's absence begins;
   - b. The 24 month period beginning on the date on which the person's absence begins for elections on or after December 10, 2004; or
   - c. 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.

Should you return to work when military service ends, the SCSD Benefits Office can provide full details concerning your eligibility for immediate enrollment and Plan Coverage according to USERRA regulations.

**G. Continuing Coverage Under COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under POMCO Standard Health 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 Syracuse City School District. 725 Harrison Street, Syracuse, New York 13210. COBRA continuation coverage for the Plan is administered by POMCO, Inc., 2425 James St., Syracuse, New York 13206, 315-432-5567 or 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 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, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

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

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee 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.

(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 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 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.
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 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:

Syracuse City School District Benefits Office  
725 Harrison Street  
Syracuse, New York 13210

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 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 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.

**COBRA Coverage and Pre-existing Conditions.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, makes it easier for an employee to change jobs and become Covered by a new employer’s plan even if the employee or his or her dependents have a pre-existing medical condition. COBRA beneficiaries must notify POMCO or the SCSD Benefits Office when they become Covered by another employer or other Group plan.

HIPAA requires that the time, in which you and your Dependents had continuous health Coverage (including COBRA) before changing jobs, will reduce, day by day, the new plan’s pre-existing condition exclusions. In this situation, COBRA Coverage ends for a beneficiary when that beneficiary becomes Covered under the new employer’s group health plan and pre-existing limitations do not apply to that beneficiary. In general, if a beneficiary or participant had health Coverage for the previous 12 months, he or she will be Covered by a new employer’s plan without regard to any pre-existing conditions. Contact your new employer to verify your Coverage and any applicable pre-existing exclusions. If you or your Dependents become eligible under a new plan, you should contact the SCSD Benefits Office to send you a Coverage certification under this Plan. When your COBRA Coverage ends, you will be provided with a Coverage certification that will describe the duration of your Coverage under COBRA. Your new employer may request Coverage certifications.

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<td>Any individual who elects to continue Coverage under COBRA will be eligible for the same Coverage in effect at the time that person first lost Plan eligibility status. Subsequent Plan Amendments apply to COBRA continuation in the same manner as for individuals who maintained Plan Coverage eligibility requirements. Benefits will not be payable for Covered Expenses Incurred during a period of COBRA continuation until the applicable Contribution payment has been made for that period of continuation.</td>
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*This continuation Coverage could be secondary payer after other group plans or Medicare. See Section VI - Coordination of Benefits. If a COBRA participant is already eligible for Medicare when COBRA continuation takes effect, the Medicare Secondary Payer Rules for persons without employment status may apply. If not already enrolled in Medicare, persons without employment status should do so immediately. Refer to Section V - Medicare Integration with Plan Benefits. If a person becomes eligible for Medicare or another health plan after COBRA continuation takes effect, Coverage under this Plan will end on the effective date of Medicare eligibility.*
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.

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

I. Certificates of Credible Coverage
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, makes it easier for an employee to change jobs and become covered by a new employer’s plan even if the employee or his or her dependents have a pre-existing medical condition. Effective 7/1/97, HIPAA requires that time, during which you and your Dependents had continuous health coverage (including COBRA) before changing jobs, will reduce, day by day, the new plan’s pre-existing conditions exclusions. Generally, this law applies to each plan based on the beginning of its plan year. In general, if a beneficiary had health coverage for the previous 12 months, he or she will be covered by a new employer’s plan without regard to any pre-existing conditions. To comply with the HIPAA provisions POMCO will send you or your Dependent a certificate of credible coverage should Coverage under this Plan end. The certificate of credible coverage will show the duration of your Coverage under the Plan. This certificate should be presented to the new employer or other Plan sponsor to reduce their pre-existing exclusion period, if any. If you or your Dependent do not receive this certificate when Coverage ends, phone POMCO and ask to have your certificate mailed immediately.
SECTION III - BENEFIT MANAGEMENT PROGRAM

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

The Benefit Management Program applies to all Enrollees whose primary Coverage is this Plan. It does not apply if your primary coverage is Medicare according to Medicare secondary payer rules or another group health benefit plan according the coordination of benefits rules for order of benefit determination. See Section V - Medicare Integration of Plan Benefits and Section VI - Coordination of Benefits.

The Benefit Management Program is designed to answer questions and explore your choices when you or your Dependent face Hospitalization, Surgery or extensive medical care. The Benefit Management Program consists of Preadmission Review, Concurrent Inpatient Review, Medical Case Management/Discharge Planning and Medical Procedure Review. This Benefit Management Program is administered by:

POMCO Benefit Management Unit
P.O. Box 6329
Syracuse, NY 13217-6329

Phone Local: (315) 432-5567 or Toll-free: 1-800-358-8399

This is a 24-hour service. If you wish to talk to the POMCO nurses, you must call between 8:00 A.M. and 4:30 P.M. on normal business days. Otherwise, provide complete information as requested by voice mail message.

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

- Enrollee’s Identification Number
- The patient’s name and address
- Physician’s name, address, and phone number
- If appropriate, name of Hospital and the anticipated date of admission or date admitted.

A. Preadmission Review

Group health plans and health insurance issuers 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 Insurers may not, under Federal law, require that a Provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Preadmission certification does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review of the Inpatient setting based entirely on the limited information provided to the Managed Care nurse at the time of the preadmission review. If medical documentation at the time services are rendered is other than provided during this initial review, and it is decided according to Plan provisions and limitations that the Hospitalization was not Medically Necessary or otherwise excluded under the Plan, benefits may be denied.
Please Note
All claims are subject to review to determine whether or not services are Covered in accordance with plan limitations. You must comply with requests for additional medical documentation as deemed necessary to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. Treatment decisions are independent from payment decisions. The patient's Physician is responsible for determining whether treatment should be rendered regardless of whether the charges are totally or partially included in, or excluded from, Coverage under this Plan.

1. Mandatory Enrollee Telephone Requirement

Others may initiate the required phone call, such as a family member, Doctor or Hospital personnel. However, it is your responsibility to confirm that the call was made. This review applies to any Hospital or other Covered facility in the USA, including Hawaii and Alaska.

The purpose of the Enrollee or Covered Person telephone call is to initiate the preadmission review and to advise the patient whether Plan Coverage is available. If this Plan is primary, you must call POMCO before a scheduled admission or after an emergency admission to any Inpatient facility or before Home Health Care Agency services are rendered. You must call as follows:

a. At least seven days before an admission or when the Physician decides that you or one of your Dependents requires admission to a Hospital, Birth Center, Skilled Nursing Facility, Psychiatric Facility, or any other Inpatient facility.
b. Within 48 hours after an emergency or urgent admission.
c. Within 24 hours for Inpatient Care more than the first 48 hours after a normal delivery of newborn or 96 hours after a caesarian section. For all other maternity admissions, follow instructions shown in a. or b. above.
d. Within 24 hours for newborn care more than the first 96 hours after birth.
e. Before home care begins when the Physician decides that you or your Dependent requires home health care services instead of confinement.

2. Noncompliance Benefit Reduction

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

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

B. Concurrent Review

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

C. Medical Case Management/Discharge Planning

If you or your Eligible Dependent requires extended care or home care, the Claims Administrator will help you make decisions concerning treatment plans and facilities to coordinate medical services and Plan benefits. This can be initiated by you or by the Claims Administrator. Participation is voluntary and can be ended any time. Coordination of services could include alternate treatment or an alternate facility. The Managed Care Unit staff will work with you and your Doctor to use services Covered by the Plan.
D. Medical Procedure Review

1. Mandatory Enrollee Telephone Requirement

   **It is your responsibility to make the required phone call(s) or to confirm such calls are made by other persons such as a family member, Doctor or Hospital personnel.**

   If this Health Plan is primary, you are required to call POMCO whenever you or your Dependent are scheduled as an Inpatient or Outpatient (Hospital, office or other Outpatient facility) for the following procedures:

   - Breast Reduction Surgery
   - Diabetic Education (exceeding or expected to exceed five visits)
   - Gastric Stapling
   - MRI /MRA (Magnetic Resonance Imaging/Angiography)
   - PET Scan
   - Transplants including but not limited to organs and stem cell transplants.
   - Varicose Vein Surgery

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

   **Please Note**

   A second opinion consultation will not be required for expenses that are not otherwise covered by the Plan. When the procedure or treatment is not covered according to Plan limitations and exclusions, POMCO will advise you that Plan benefits are not available. This will be done at the time of your phone call and also by letter. In this case, a second opinion will not be requested.

2. Mandatory Second Opinion Consultation (SOC). You or your Dependent may be required to obtain a Second Opinion Consultation (SOC) from a Physician whose specialty is similar to the attending Physician. If you or your Dependents are required to obtain a SOC, you may seek this consultation from a POMCO Network Provider and benefits will be reimbursed in full with no Copayment. If you seek this consultation from a Nonparticipating Provider, the benefit will be reimbursed in full up to the Usual, Customary and Reasonable (UCR) Charges for this service. The SOC must be secured from a board-certified specialist in the appropriate field of medicine for which the patient is contemplating Surgery and must not be a part of the same medical or surgical group as the first opinion Physician. After the SOC, it is up to you or your Eligible Dependent whether to proceed with the procedure. If you decide to go ahead, usual Plan limitations and exclusions apply to the procedure expenses. However, if the SOC specialist does the procedure, Plan benefits will not be paid for the SOC.

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

3. SOC Noncompliance Benefit Reduction. If you do not comply with the requirements of this review and you or your Dependent receives one or more of the listed procedures, you will be responsible for the payment of the following:

   a. In addition to any applicable Copayments, 50% of the scheduled allowance or $250.00, *whichever is less*, for services by a *Network Provider*; or
   b. In addition to the major medical Copayment and Deductible amounts, if applicable, 50% of the Allowable Fees or $250.00, *whichever is less*, for services by an *Out-of-Network Provider*; and
   c. If the patient is admitted to the Hospital as an Inpatient for a procedure that required a SOC and for which one was not obtained, you will be liable for a *benefit reduction of $250.00* of the available Hospital benefit or
other approved Inpatient facility benefits.

### Please Note

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

### E. Alcohol/Substance Abuse Facility-Outpatient Care Review

The facility or agency must submit a care plan to the POMCO Managed Care unit at the time of initial assessment and before treatment begins. The Claims Administrator will review the care plan and advise the facility or agency and you whether Coverage is available under the Plan. If care plan is not submitted for preapproval or if the care plan is not approved for Plan Coverage, benefits will not be paid.
SECTION IV - COVERED SERVICES

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

The following pages provide details of your Coverage. Covered Services are subject to Plan limitations and exclusions. All benefits are based on Allowable Fees for Covered Services and Supplies. Allowable Fees for Network Providers are the negotiated or scheduled network allowances for Covered procedures. For Nonparticipating Providers, Allowable Fees are the Usual, Customary, and Reasonable (UCR) Charges for Covered Services. Charges that are more than Allowable Fees are not Covered. See Section I - Summary of Benefits for information on benefit limits, Appendix B - Definitions for more information concerning terms that may apply to the Plan, and Appendix C - Plan Exclusions for details on expenses not Covered under the Plan.

A. Participating Provider Network Program (Network)

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

Participating Providers have a written agreement to accept a scheduled or negotiated (network) allowance as their charge for most Covered Services and Supplies. Available Plan benefits are paid directly to the Participating Provider (Network Provider). The Network Provider submits claims directly to POMCO. Each Network Provider maintains their own professional liability insurance. Neither POMCO nor the POMCO Allied Network gives advice relating to medical care, they are administrative bodies only.

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

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

Please Note

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

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

1. Well Child Care. Benefits are available for routine well child care rendered for eligible and enrolled Dependent children from birth through age 18. Coverage is to be consistent with the clinical standards set forth by the American Academy of Pediatrics (AAP). The AAP reviews and modifies its recommendations periodically; the latest standards are available in the SCS District Benefits Office. Routine well child care rendered in a Physician's office, Hospital or clinics licensed to render such care, includes the following services only:

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

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<th>Please Note</th>
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<td>To be eligible for benefits from the moment of birth, your child must be enrolled in family Coverage within 30 days from the date of birth. If you fail to enroll the newborn within 30 days from the date of birth, Coverage cannot begin until after the date of enrollment according to Plan provisions.</td>
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b. Well Child Care/Immunizations. If this Plan is the primary payer, the following Physician services are Covered when rendered and billed for your Dependent child from birth up to age 19.

1) Usual well child laboratory screening and testing.
2) Usual routine well child physical exams by a Physician (including a pediatrician, family practitioner and gynecologist, or other professional licensed to render preventive care services).
3) Developmental assessments.
4) Age appropriate immunizations for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis b, haemophilus influenza type b., varicella (chicken pox) based on the current schedule for immunizations or guidelines recommended by the American Academy of Pediatrics. Immunizations given later than the recommended age level will still be Covered if administered to the child before age 19. Immunizations for other diseases may be Covered when set forth by the American Academy of Pediatrics standards. Plan Coverage will also be available for well child immunizations required by New York State Law or designated by the New York State Superintendent of Insurance.

5) Well child care Coverage is available for usual visit frequency as follows:
   a) At birth, for Newborn Routine Nursery Care and one pediatric evaluation within 48-72 hours after discharge for breastfeeding infants or for those discharged from the Hospital before 48 hours after delivery;
   b) In addition to a) above, the Plan covers one health care visit during the first month following birth, then up to five (5) visits to age 12 months; then
   c) Up to four (4) visits to age 24 months; then
   d) One visit per year to age 19.

Please note: The AAP also recommends that sexually active at-risk females from age 11 should have a pelvic examination. A pelvic examination and routine Pap smear should also be offered as part of preventive health maintenance from age 18 years. This exam can be substituted for the annual well child exam.
2. **Mammography Screening.** Benefits are available for Allowable Fees billed by a Hospital, clinic, or Doctor for routine mammography screening under the following conditions:

a. With a Doctor’s orders, Covered Persons, at any age, with a personal medical history of breast cancer, or whose mother or sister has a history of breast cancer;

b. A single baseline mammography for Covered Persons 35-39 years of age;

c. An annual mammography for Covered Persons 40 years of age or older.

3. **Adult Routine Physical or Exam**

| Benefits are available for annual routine health exams or general physicals rendered by Physicians for **active Employees age 50 or older.** Coverage includes related routine tests and is limited to once per Calendar Year for each Covered active Employee, age 50 or older. |

4. **Annual Gynecological (Gyn) Exam/Pap Test (Network Provider Coverage Only)**

| This benefit is not available if services rendered by Out of Network Providers or if this Plan is secondary to another Plan (except Medicare) providing this benefit. |

Routine cervical cancer screening (Pap smear tests) and related gynecological exams rendered and billed by Network Hospitals, clinics, independent labs, or Doctors are only available as a Network benefit. Coverage is limited to once per 12 consecutive months for eligible females.

5. **Routine Colonoscopy.** For Persons not considered at risk for colon cancer, benefits are limited to one screening every 10 years for Covered Persons between the ages of age 55-64. This benefit will extend from July 1, 2006 through June 30, 2009 and will be reviewed annually.

**C. Hospital Expense Benefits**

1. **Acute Care General Hospital**

| Benefits are available for Allowable Fees billed by an acute care General Hospital for Outpatient and acute care Inpatient services. Covered Services must be actually rendered and must be recommended by the attending Physician for any care needed by you or your Eligible Dependent. Such care must be Medically Necessary according to the provisions of the Plan. Services and supplies must be provided by the Hospital and rendered by employees of the Hospital. The person receiving services or supplies must be admitted to the Hospital for Inpatient Care or be present for Outpatient care. After Hospital Expense Benefits are exhausted, additional Coverage is available under **Major Medical Expense Benefits** shown later in this section. Charges for Physician services and private duty nurses are Covered separately under Major Medical Expense Benefits. Benefits are not available for separate charges billed for professional services by Hospital employees or staff. |

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

Inpatient Services.

1) **Room and Board** (including general nursing) in semi-private rooms (two or more beds), intensive care units, critical care units, cardiac care units or similar units. If confined in a private room, the Plan allows the Average Semi-Private Rate. You will be responsible for payment of charges more than the Average Semi-Private Rate. Room and board charges billed for the date of discharge are not Covered.
2) **Ancillary or Miscellaneous** medical supplies or medical services received during an Inpatient period in which room and board charges are Covered. Coverage includes, but is not limited to, diagnostic tests, Rehabilitative therapy, respiratory therapy, drugs and medicines, dressings and other medical supplies, anesthesia supplies, operating room and recovery room, use of Hospital equipment, et. al. Take home supplies or drugs are not Covered under this benefit. Personal services such as telephone, TV, barber, etc. are not considered medical expenses and will not be paid.

3) **Medical/Surgical Benefit Limit** is 365 days per Spell of Illness for room and board and ancillary charges. See below for separate limits for Psychiatric Care. Refer to **Appendix B - Definitions** under Spell of Illness for explanation.

4) **Psychiatric Care** is Covered the same as any other Illness. However, Coverage is provided only when the patient requires such care for the protection of himself or others or where the course of treatment can only be carried out on an Inpatient basis. (This benefit is provided for Acute Care General Hospital. Separate Hospital Expense Benefits are available for Inpatient Care in Psychiatric Facilities. See **Psychiatric Facility** shown later in this sections.)

5) **Maternity or Pregnancy** care is Covered the same as any other illness including but not limited to childbirth, miscarriage, legal elective/voluntary abortions and other termination of Pregnancy.

6) **Newborn Nursery Care** is Covered when your newborn is Covered in your family Plan within 30 days from the moment of birth. Coverage is available for sick and routine care. Routine nursery care is limited to four days. Care after four days will only be Covered if the child requires continued care due to specific medical condition. If routine nursery care is extended primarily due to the mother’s continued stay, benefits will not be available for the additional days even if the mother provides personal newborn care, such as breastfeeding.

b. **Outpatient Services.** Benefits are available for certain Outpatient services billed by the Hospital. Refer to **Preventive Care Expense Benefits** shown previously in this section for additional limited Coverage. Copayments could apply; refer to **Section I - Summary of Plan Benefits** for details. Coverage under this benefit is limited to services and supplies rendered for the following Outpatient care:

1) **Emergency Care** or initial treatment within 72 hours of an Accidental Injury that requires this type of care or within 12 hours of the first acute symptoms of a sudden and serious Illness. The sudden and serious Illness must be such that failure to provide emergency care could reasonably be expected to result in serious impairment of body function or jeopardize the patient's life.

2) **Surgery** services and supplies by the Hospital are Covered. This includes services related to setting of a fracture or dislocation. However, follow up care such as removal of sutures, recheck exams etc., are not Covered under this benefit.

3) **Radiation or X-ray Therapy** services and supplies by the Hospital are Covered.

4) **Diagnostic X-rays, Laboratory and other Diagnostic Tests** are Covered when ordered by the Physician for diagnosis of specific symptoms or when related to treatment of an Illness or Injury. Routine or preventive diagnostic services are not Covered.

5) **Preadmission Testing** is Covered when all of the following requirements are met:
   a) The tests are ordered by a Physician as a preliminary requirement for you or your Dependent's admission as a registered bed patient for Surgery in the same Hospital;
   b) Tests must be consistent with the diagnosis and treatment of the condition for which Surgery is needed;
   c) The reservation for a Hospital bed and operating room was made before testing was done;
   d) The patient must be physically present at the Hospital for needed tests;
e) Surgery must take place within 7 days after the tests are given. Separate charges for the use of the Hospital emergency or Outpatient room are not Covered under this benefit.

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

The Claims Administrator will periodically request medical records to confirm that the therapy is resulting in improved function and is expected to continue to improve function based on a treatment plan with defined goals to be accomplished within a reasonable period of time. This review will also confirm that the Physician continues to order the Physical Therapy and sees the patient on a regular basis for the reported condition. Under no circumstances will the Plan pay expenses for any period of Physical Therapy that was not specifically ordered by the attending Physician. Benefits will not be paid for care rendered when the patient has met maximum functional improvement or for Maintenance Care.

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

7) **Inhalation Therapy** is Covered when ordered by the attending Physician and found Medically Necessary according to Plan Provisions. Separate charges for use of the Outpatient or emergency room are not Covered under these benefits.

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

2. **Ambulatory Surgical Facility**. Benefits are available for services and supplies rendered by a licensed Ambulatory Surgical Facility for Covered surgical procedures to the extent expenses would have been allowed if provided by a Hospital. Coverage includes related facility services and supplies on the day of Surgery. Charges for professional services such as surgeon, assistant surgeon or anesthesiologist are Covered separately.

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

4. **Skilled Nursing Facility (SNF) Inpatient Care**

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

Each Covered Inpatient day equals ½ benefit day. For example, 20 Inpatient days will count as 10 benefit days. Benefit days are limited to 365 days per Spell of Illness and count toward the acute care General Hospital 365-day limit per Spell of Illness. Additional Coverage for Inpatient SNF expenses is not available under **Major Medical Expense Benefits**.

   a. Benefits are available for Inpatient SNF charges when care meets all of the following criteria:

   1) Coverage will only be provided for as long as Inpatient Care in an acute care General Hospital would have been necessary if care in a Skilled Nursing Facility were not provided; and
2) Diagnostic and therapeutic services must be provided and billed by the facility and rendered by employees of the facility.

b. **Covered SNF services** are limited to the following:

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

5. **Home Health Care Agency**

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

Benefits are available for an Approved Plan of Care for home care services when rendered and billed by an accredited and certified Home Health Care Agency. To be eligible for this benefit, the patient's condition must be such that confinement in a Hospital or Skilled Nursing Facility would be necessary if home health care services were not provided. Care must be preapproved through the Benefits Management Program and based on written approval by the attending Physician.

Up to four hours of care per day by each member of the home care team is considered one visit. Benefits are limited to 40 visits per Calendar Year. Additional Coverage is not available under **Major Medical Expense Benefits**.

The following services are Covered under this benefit:

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

b. Part-time or intermittent Home Health Aide services rendered primarily for the care of the patient. Full time care is not Covered;

c. Rehabilitative physical, occupational and speech therapy;

d. Medical Supplies, drugs and medicines that would have been allowed if the patient were confined;

e. Laboratory services that would have been Covered if rendered during an Inpatient stay in a Hospital or Skilled Nursing Facility. Coverage includes laboratory services billed by the Home Health Care Agency for its services or by an outside laboratory designated to render such services on behalf of the agency.

6. **Hospice Care Agency**

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

Benefits are available for the period during which the hospice care agency accepts the patient in its program. The patient must be diagnosed as terminal with six months or less to live. During this period of acceptance, all the patients’ medical services must be provided by or obtained through the hospice care agency. All services must be billed by the hospice care agency. Coverage is limited to 180 days of hospice care. Allowable Fees are limited to $250.00 per day. Exception: Charges for drugs and Acute Care General Hospital expenses will be allowed at Usual, Customary, and Reasonable (UCR) Charges. Benefits are available for the following hospice services and supplies:

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

7. **Psychiatric Facility.** Refer to Section I - Summary of Benefits for Calendar Year benefit day limits for any combination of Psychiatric Facility and acute care Hospital stays.

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<th>Phone calls are required by you before Inpatient admissions to a Psychiatric Facility. Refer to Section III - Benefit Management Program for instructions.</th>
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| a. **Private Psychiatric Facility.** Inpatient Care is Covered when ordered by the attending Physician when the patient requires Inpatient Care to protect himself or others or where the course of treatment can only be carried out on an Inpatient basis. 

Services must be Medically Necessary and pre-approved for Coverage through the Benefit Management Program. Benefits will not be paid if services are obtained without such pre-approval or if the Claims Administrator does not approve Coverage for any portion of an Inpatient stay.

Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training. Additional Coverage is not available under Major Medical Expense Benefits. Separate charges for staff Physicians, nurses and other facility employees are not Covered.

b. **Government-Owned Psychiatric Facility.** Benefits are available for care in a government-owned psychiatric facility only when the Covered Person is admitted in an emergency/crisis situation, or on a holiday or weekend. However, after the psychiatric condition stabilizes, the allowable fees will be subject to the Major Medical Deductible if the Covered Person remains in the government-owned facility after a bed becomes available in an Acute Care General Hospital or Private Psychiatric Facility.

8. **Alcohol/Substance Abuse Facility.**

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</table>
| a. **Inpatient** 

Benefits are available for Inpatient diagnosis and treatment of alcohol and or substance abuse rendered and billed by a certified Alcohol/Substance Abuse Facility when preapproved through the Benefit Management Program. Benefits will not be paid if services are obtained without such preapproval. Benefits will not be paid if the Claims Administrator does not approve Coverage for any portion of an Inpatient stay. Coverage for preapproved Inpatient days will be limited to a maximum of 30 days per Calendar Year and 60 days per lifetime for each Covered Person. Days do not count toward the General Hospital per Spell of Illness maximum. If a private room used, charges more than the Average Semi-Private Rate will be excluded. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training. Refer to Section I - Summary of Benefits for benefit limits. Additional Coverage is not available under Major Medical Expense Benefits. Separate charges for staff...
Physicians, nurses or other employees are not Covered.

b. Outpatient. Benefits are available for eligible Enrollee and Eligible Dependents for an Approved Plan of Care for Outpatient services rendered by a certified alcohol or certified Substance Abuse Facility (freestanding agency or facility or a Hospital center) for the diagnosis and treatment of alcoholism or substance abuse. Each visit must consist of at least one of the following: individual or group counseling; activity therapy; and diagnostic evaluations by a Doctor or other licensed professional to decide the nature and extent of the patient's Illness. Benefits are not payable for visits that consist primarily of participation in programs of a social, recreational, or companionship nature. The employees of the facility must render services provided by the facility.

Coverage for Outpatient treatment is limited to 60 benefit days per Calendar Year and up to 180 benefit days per lifetime for each Covered Person. Up to 20 of the 60 visits may be used for counseling for the affected person's Covered family members. Five of the 20 family member counseling visits are payable even if the affected person is not receiving care. Family member visits are only payable for services rendered for enrolled family members under a family plan. One visit per day will be allowed, except a family member counseling visit that takes place separately from the patient's individual visit on the same day. The same allowable amount will be paid for a family member visit, whatever the number of family members attending the counseling session. Additional Coverage is not available under Major Medical Expense Benefits.

9. Ambulance. Benefits are available for emergency land ambulance transportation for you or your Eligible Dependents when found Medically Necessary, according to Plan provisions. Air 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 ambulance may also be reimbursed if the location, from which the patient required emergency transportation, was inaccessible by land ambulance.

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

Benefits are payable for emergency transportation by professional ambulance or volunteer ambulance. Benefits are not payable if the patient could have been safely transported by any other means of transportation. No other type of transportation is Covered, whatever the reason.

a. Professional or Hospital-Owned Ambulance services are Covered when ordered by a police officer or Physician for transportation to the nearest Hospital that can provide treatment for the patient's Illness or Injury. Coverage is also provided for emergency services rendered by ambulance staff if medical treatment can be safely provided onsite and the patient does not need to be transported to a Hospital. Other Professional Ambulance Coverage will be determined on a case-by-case basis by the Claims Administrator.

b. Volunteer Ambulance is Covered on the same basis as professional ambulance if the ambulance service normally bills for its service.
D. Medical/Surgical Expense Benefits

This portion of the Plan allows Full Benefits for Allowable Fees after applicable Copayments, if any, for certain services rendered and billed by Physicians. Such services must be found Medically Necessary for the treatment of Illness or Injury, according to Plan provisions. The following services are Covered under this benefit:

Some medical procedures require a phone call before care begins. Refer to Section III - Benefit Management Program.

1. Surgical Services. Medical services rendered and billed by a Doctor are Covered for the following:

   a. Surgery benefits are available for Allowable Fees billed for surgeons’ services when found Medically Necessary according to Plan provisions. When two or more procedures are done during the same operative session, the fees for the secondary procedures may be allowed at a reduced fee of 50% of the Usual, Customary, and Reasonable (UCR) Charge. The surgical allowance includes the usual care given by the Provider before and after Surgery. Separate charges for care considered postoperative will not be paid. Separate charges for procedures or services considered part of, or incidental to, the surgical procedure will not be paid.

   b. Maternity Services rendered by a Doctor or a certified nurse midwife (for services within the scope of midwife license) are covered on the same basis as other surgical services including but not limited to childbirth, miscarriage, legal elective/voluntary abortions and other termination of Pregnancy. The allowance for childbirth or termination of Pregnancy includes the usual care given before and after delivery by the same Provider. Benefits will be determined on the same basis as Surgery shown previously in this section. If the patient changed Providers during prenatal or postnatal care, and that Provider bills separately for his or her visits, Coverage will be based on type of care rendered (Hospital visits or office visits).

   c. Assistant Surgeon services will be Covered when such assistance is found Medically Necessary to do the surgical procedure. (A Hospital rule or requirement does not, in itself, establish Medical Necessity). The assistance must be in a Hospital or other facility where there is no qualified staff available to assist the surgeon. The Allowable Fees for the assistant surgeon will be based on 20% of the Usual, Customary, Reasonable (UCR) charges or 20% of the fees allowed for the surgeon whichever is the lowest amount.

2. Anesthesia Services. Benefits are available for Allowable Fees billed by an anesthesiologist when found Medically Necessary for a Covered surgical procedure. Benefits are not available for separate charges billed for administration of anesthesia by the surgeon, assistant surgeon or Hospital employee. The anesthesia benefit includes the anesthesiologist patient consultation before anesthesia service is given and usual care after Surgery. Anesthesia for shock therapy and non-surgical care is Covered when found Medically Necessary according to Plan provisions.

3. Inpatient Physician Visits. Benefits are available for Physician evaluation and management visits during an approved stay in a Hospital or Skilled Nursing Facility. Services received for the in-patient treatment of mental health disorders will be allowable only during a period in which benefits are payable for facility room and board services. Coverage is limited to one visit per day for the Physician in charge of the treatment for conditions. Benefits are not available for the surgeon’s post-operative care or delivering Doctor or for the Doctor substituting for the surgeon or delivering Doctor during post care. Coverage is limited to once per day up to a maximum of 120 days per Spell of Illness. Coverage for Mental Illness is Covered separately. See Mental Illness Inpatient Visits shown later in this section. There are instances when more than one visit per day could be paid, these count toward the 120-day per Spell of Illness limit and are as follows:

   a. Consultations - A consultation is a one-time examination requested by your attending Physician for the evaluation of your Illness or Injury. When your Doctor requests a consultation, benefits will be provided for as many different consultants as necessary. However, if the consultant gives further care, all visits will be considered as medical visits, not consultations.
b. **Special Visits** - If your Illness or Injury is so critical or serious that it requires constant personal attention by a Doctor, benefits will be provided up to a maximum of five hours of such care for each visit. If a special care visit is paid, it will be counted as an Inpatient medical visit for that day.

c. **Care by More than One Physician** - If you are a registered bed patient in a Hospital and two or more Providers treat you for separate and different conditions, these visits will be paid when the visits of each Provider are medically required for the treatment of the separate conditions.

d. **Medical Care in a Skilled Nursing Facility or Nursing Home** - As part of the 120 days available for in-Hospital medical care, benefits will be provided when a Doctor visits you in a Skilled Nursing Facility or nursing home. To be eligible for this benefit, you must be admitted to the facility within 14 days following discharge from the Hospital, and if your stay in this facility is Medically Necessary.

4. **Mental Illness Inpatient visits/Acute Care General Hospital or Private Psychiatric Facility**. Coverage is limited to visits during room and board benefit days approved for Inpatient Mental Illness under Hospital Expense Benefits. Coverage is limited to one visit each day up to 120 days per Calendar Year for acute care General Hospital visits and up to 90 days per Calendar Year in private Psychiatric Facility. In no event, will the Plan pay more than 120 Inpatient visits per Calendar Year for any combination of acute care General Hospital or private Psychiatric Facility stays. Additional Coverage is not available under **Major Medical Expense Benefits**.

5. **Second Surgical Opinion Consultation**. Benefits are available for Second Surgical Opinion Consultations when you or Eligible Dependent wants to obtain a second opinion before proceeding with a Covered surgical procedure. A board-certified specialist Doctor whose specialty is appropriate to consider the need for that surgical procedure must render the second opinion. If the consulting Doctor renders the Surgery or if the consultant is part of the same Physician or specialty group as the same Physician who first recommended the surgical procedures, second opinion benefits will not be paid.

6. **Radiation or X-ray Therapy**. Benefits are available for radiation therapy procedures and supplies rendered and billed by a Physician. However, the cost or rental of substances used for radiation therapy is Covered separately under **Major Medical Expense Benefits** shown later in this section.

7. **Diagnostic X-rays and Machine Testing**. Benefits are available for Diagnostic X-rays and Machine Tests rendered and billed by a Physician when found necessary for diagnosis and treatment of Illness or Injury. Coverage includes charges by a Physician for professional interpretation of Covered diagnostic tests that were done by a Hospital when the Physician has a written agreement to provide such services. Charges for routine or preventative tests are not Covered under this benefit.

8. **Diagnostic Laboratory and Pathology Tests**. Benefits are available for diagnostic lab and pathology tests rendered and billed by a Physician or independent lab when found to be Medically Necessary for diagnosis and treatment of Illness or Injury. Coverage includes charges by a Physician for professional interpretation of Covered diagnostic tests that were done by a Hospital when the Physician has a written agreement to provide such services. Charges for routine or preventative tests are not Covered under this benefit.

9. **Emergency Physician Care**. Benefits are available for emergency Outpatient services rendered and billed by a Physician for emergency care under the following circumstances:

a. **Accidental Injury** - When care for treatment of an Injury is necessary and rendered within 72 hours of after the accident.

b. **Sudden and Serious Illness** - When care is rendered within 12 hours after the onset of acute symptoms for a sudden and serious Illness. The medical condition must be so severe that if immediate medical care were not given, the condition would endanger the life or cause serious impairment to bodily functions of the patient.
E. Major Medical Expense Benefits

Unless shown otherwise, Allowable Fees for Covered Services are subject to the Calendar Year Deductible, Copayment limit, and lifetime benefit maximums. Refer to Section I - Summary of Benefits under Major Medical Expense Benefits for details.

Major Medical Expense Benefits become available after Hospital Expense Benefits and Medical/Surgical Expense Benefits are exhausted. Benefits are available for Covered hospital, medical and surgical expenses incurred by you or your Eligible Dependents when ordered by a Physician and found Medically Necessary for treatment of Illness or Injury according to Plan provisions.

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

1. Acute Care General Hospital. Major Medical Benefits are not available for Inpatient Mental Illness care. See Hospital Expense Benefits shown previously in this section.

   a. Inpatient Services. After Hospital Expense Benefits are exhausted, this benefit becomes available for acute care Inpatient treatment of Illness or Injury. However, this benefit is not available for Mental Illness care. Coverage includes room and board and ancillary charges on the same basis as shown under Hospital Expense Benefits. If a private room is used, you will be responsible for charges more than the average semi-private room rate unless private room is ordered by the attending Physician and found Medically Necessary according to Plan provisions. Use of private room that is primarily at the request of the patient or family member will be limited to semi-private rates even if ordered by the Physician. Coverage for Physicians and private duty nursing expenses is considered separately.

   b. Outpatient Services. After Hospital Expense Benefits are exhausted, this benefit becomes available for Medically Necessary services and supplies provided for Hospital Outpatient services. To be eligible, medical services and supplies must otherwise be Covered under the Plan, subject to the same limitations. Coverage for Physician services is considered separately.

2. Doctor Services

   a. Inpatient Physician Care. After Medical/Surgical Expense Benefits are exhausted, benefits become available for Inpatient Physician visits during an approved stay in a Hospital or Skilled Nursing Facility. These benefits are Covered except surgeons' post operative or post obstetrical care. However, this benefit is not available for Inpatient Mental Illness. See Medical/Surgical Expense Benefits shown previously in this Section. The Physician in charge of the treatment for conditions other than Surgery or obstetrical care will usually be Covered for one visit per day under this benefit. Additional Physicians or Physician visits will be considered when found Medically Necessary according to Plan provisions. For example: When patient’s Illness is so critical or serious it requires more attention by the Doctor, or complications during post-operative care. Care by more than one Physician will be considered when each Provider gives medically required treatment for separate and different conditions. Benefits are not provided for Physician visits for treatment found to be Custodial Care.

   b. Outpatient Care. Benefits are available for care rendered by Physicians on an Outpatient basis, such as in his or her office, in the Outpatient Hospital or Skilled Nursing Facility, in the patient’s residence (home or nursing home) or other Outpatient location. Coverage includes the Physician medical services and related supplies found Medically Necessary for the treatment of an Illness or Injury, according to Plan provisions. Mental Illness care is Covered separately under Outpatient Mental Health Care shown later in this section.

   c. Specialist Consultations. After Medical Surgical Expense Benefits are exhausted, this benefit is available for specialist consultations requested by the attending Physician to obtain an opinion in the evaluation of
management of an Illness or Injury. Coverage is provided for Inpatient and Outpatient consultations and includes the specialist exam, necessary tests and written reports. Referral must be made by the attending Physician for the specialist opinion. The specialist exam will not be considered a consultation if a referral is made by friends, relatives or by a Doctor who is not considered an attending Physician. The consultant must be a board-certified specialist whose specialty is appropriate to render an opinion for that person’s condition. However, if the specialist takes over the management (treatment) of the condition, subsequent management visits are not considered consultations. When the attending Physician refers a patient to a specialist for the management (treatment) of an Illness or Injury, the visits are not considered consultations.

3. **Chiropractic Services.** Benefits are available for services by a licensed chiropractor for care related to the scope of their practice, including but not limited to manual spinal manipulation and X-rays. Diagnostic X-rays are Covered separately under **Medical/Surgical Expense Benefits** shown previously in this section. Care must be directed at improvement or correction of the spinal subluxation. Benefits are not payable if maximum improvement has been met or if found to be Maintenance Care according to Plan provisions. If care no longer results in improvement of function or is found to be Maintenance Care according to Plan provisions, benefits will not be paid for that care. The Claims Administrator may periodically request medical records to confirm whether active or Maintenance Care.

4. **Podiatry Services.** After Medical/Surgical Expense Benefits are exhausted, foot care rendered by a licensed Podiatrist is Covered when found Medically Necessary for treatment of Illness or Injury of the feet. Coverage includes office visits, diagnostic services, surgical services and other usual care needed for the treatment of foot disorders. However, Plan excludes routine foot care and certain chronic foot disorders. Refer to **Appendix C - Plan Exclusions** for details. Exception: Routine foot care recommended by a medical Doctor related to the care of an insulin-dependent diabetic may be considered for benefits.

5. **Private Duty Nursing.** Benefits are available when private duty nursing services are ordered by the attending Physician and found Medically Necessary according to Plan provisions. Services must be provided by and require the skills of a registered professional nurse (RN). Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or Household Member. If rendered during a Covered Inpatient stay, care must be so intense that the Hospital or Skilled Nursing Facility staff could not be expected to render such care. Shortage of general nursing staff does not establish Medical Necessity for private duty nurses. Benefits are not available for Custodial Care or Maintenance Care, companionship, or care that is primarily assistance with daily living or other services that do not require the skills of an RN. A licensed practical nurse may be allowed if the Doctor certifies that a registered nurse is unavailable for 24-hour skilled nursing care.

6. **Physical Therapy.** Benefits are available for short term Rehabilitative physiotherapy by a licensed physical and/or occupational therapist of the type and duration ordered by the attending Physician. Therapy must be needed to restore body function lost due to an Illness or Injury. If you or your Dependent reaches maximum potential for significant and measurable improved function or if treatment is found by the Claims Administrator to be Maintenance Care, benefits will no longer be available. If care is initially approved for Coverage, the Claims Administrator may periodically request medical records to confirm whether care continues to restore function or is considered Maintenance Care. Exercise programs and use of body exercise equipment are not Covered.

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

Early intervention services, treatment and rehabilitation for children with physical disabilities, and other Special Education Programs that are covered under the NYS Dept. of Health are excluded under this Plan so that benefits will not be duplicated.
7. **Speech Therapy.** Benefits are available for short-term Rehabilitative speech therapy by a licensed speech therapist when ordered by an attending Physician. Coverage is limited to speech therapy needed to restore Speech Function lost due to an Illness or Injury or to improve Speech Function following Surgery for correction of a birth defect that caused speech dysfunction. Other congenital anomalies (not corrected by Surgery), brain dysfunctions, or developmental delays will not be paid. Speech therapy must be directed at significant measurable restoration and improvement of Speech Function. If the patient reaches maximum potential for improved or age appropriate function, benefits will no longer be available. If therapy is initially approved for Coverage, the Claims Administrator may periodically request medical records and/or progress reports to confirm whether care continues to restore Speech Function. Speech therapy is not Covered for stammering, stuttering, lisping or mild articulation disorders. Benefits are not available for myofunctional or tongue thrust therapy.

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

Early intervention services, treatment and rehabilitation for children with physical disabilities, and other Special Education Programs that are covered under the NYS Dept. of Health are excluded under this Plan so that benefits will not be duplicated.

8. **Durable Medical Equipment (DME).** Benefits are available for the rental or purchase, if appropriate, of Durable Medical Equipment when ordered by an attending Physician and found Medically Necessary according to Plan provisions. Purchase will be allowable if the DME cannot be rented or if rentable equipment is needed for an extended period that would make the purchase less costly than continued rental. Equipment must customarily be used for therapy and suitable for home use. Coverage includes necessary supplies to operate the equipment. Examples of Covered DME are standard Hospital beds, ventilators, canes, crutches, walkers, and wheelchairs. Such equipment, for example, does not include hearing aids, eyeglasses, contact lenses, blood pressure monitors, thermometers, shoes or other articles of clothing, communication devices, computers, air conditioners or purifiers, humidifiers, exercise equipment, comfort items or convenience items. The necessary repairs and maintenance of purchased equipment will be allowed unless Covered by a warranty or purchase agreement. Duplicate DME is not Covered. Replacement of DME is Covered only when the existing DME is no longer serviceable due to change in body condition or is no longer repairable (wear and tear). Charges for delivery and service are not Covered. For additional limitations on this service, refer to **Appendix B - Definitions** under **Durable Medical Equipment**.

9. **Prosthetics/Orthotics/Braces.** Benefits are available for the purchase or repair of Prosthetics, orthotics or braces when ordered by a Doctor and found Medically Necessary according to Plan provisions. The devices or appliances must replace the function of physical organs, limbs or other body parts or must aid in their function. Coverage includes orthotics or braces needed to support or align movable parts of the body, prevent or correct deformities. However, the Plan excludes devices, supports or orthotics used for foot disorders, except when needed after an open cutting surgical procedure. Benefits are not payable for duplicate Prosthetics, orthotics or braces. However, replacement of Prosthetics, orthotics or braces will be Covered when the existing device or
appliance is no longer serviceable due to change in body condition or is no longer repairable (wear and tear). Replacement of a device due to loss or theft is excluded. Purchase of biomechanical Prosthetics is excluded.

Examples of Covered devices or appliances are braces, post mastectomy breast Prosthetics (including surgical bras), artificial arms, legs and eyes used to replace or to support functioning parts of the body. Contact lenses (or eyeglasses instead of contact lenses) and related exams are Covered when the contact lenses perform the function of the human lens and are medically required because of intra ocular Surgery, cataract Surgery or other absence of the organic lens. Contact lenses or eyeglasses prescribed for any other purpose are excluded. Limited Coverage is available for a hairpiece or wig when ordered by the Doctor for hair loss due to chemotherapy. (The Plan will pay up to a maximum of $500.00 for one hairpiece or wig per the Covered Person’s lifetime.) Hairpieces or wigs needed for any other purpose are excluded. Coverage does not include, for example, hearing aids, computers, communication devices, cosmetic devices, dentures, other devices used in connection with teeth, foot orthotics, or devices otherwise excluded under the Plan.

10. Mental Illness Outpatient Care. Alcohol or Drug addiction services are not Covered under this benefit. Refer to Hospital Expense Benefits shown previously in this section.

Benefits are available for Mental Illness care rendered by a licensed psychiatrist (medical Doctor), licensed clinical psychologist, accredited Certified Psychiatric Social Worker or a Certified Psychiatric Nurse when found Medically Necessary according to Plan limitations. Treatment must be directed at a diagnosed Mental Illness. Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy which includes the satisfaction of requirements for professional training. Refer to Section II - Summary of Benefits for benefit limits. Following exhaustion of benefit limits, the Enrollee may contact the SCSD Employee Assistance Program Coordinator for a review of their circumstances. Refer to Section X - Employee Assistance Program.

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

a. Ostomy bags and supplies required for their use.

b. Catheters and supplies required for their use.

c. Syringes and needles necessary for conditions such as diabetes. See Diabetic Supplies, Equipment and Education shown later in this section.

d. Extensive dressings necessary for conditions such as cancer, diabetic ulcers and burns. Your Physician must order the use of these supplies.

12. Chemotherapy. Benefits are available for non-Experimental chemotherapy rendered and billed by a Hospital or by a Physician for Outpatient services (Outpatient department or office) when found Medically Necessary according to Plan provisions. Non Experimental home chemotherapy (intravenous), drugs, supplies and equipment will be Covered for an Approved Plan of Care when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Professional services are Covered separately. Home care requires approval through the Benefit Management Program. The prescription drug obtained from a pharmacy is generally payable under the SCSD Pharmacy Benefit Manager Prescription Drug program.

13. Kidney Dialysis. Services and supplies for kidney dialysis are Covered when rendered and billed for Outpatient services rendered by a Hospital, Physician, at home or by a Medicare certified freestanding hemodialysis facility. Home care dialysis includes consumable and expendable supplies and Durable Medical Equipment found Medically Necessary according to Plan provisions. Benefits will not be paid for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, air conditioning, or for convenience or comfort items.
Please note
A person receiving kidney dialysis could be eligible for Medicare due to End Stage Renal Disease (ESRD). Refer to Section V - Medicare Integration with Plan Benefits.

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

15. Oxygen and its Administration (Self-Care Home use). Benefits are available for oxygen and the needed supplies for its administration when ordered by an attending Physician for self-care home use. Oxygen must be found Medically Necessary, according to Plan limitations, for use in the treatment of severe hypoxemia (low oxygen levels in the blood) caused by chronic pulmonary conditions. For example: Chronic obstructive pulmonary disease, pulmonary fibrosis, congestive heart disease, pulmonary hypertension, and cystic fibrosis. Oxygen and the needed supplies for its administration will be Covered when prescribed by the attending Doctor and when determined by the Claims Administrator to be appropriate for home use.

16. Diabetic Supplies, Equipment and Education

a. Supplies and Equipment. Benefits are available for diabetic supplies and equipment ordered by a Physician for you or your Eligible Dependents. Supplies or equipment must be found Medically Necessary, according to Plan provisions, for the treatment of diabetes. Coverage for this benefit is limited to the following items:

1) Blood glucose monitors and blood glucose monitors for the legally blind
2) Diagnostic testing agents, test tapes or strips, for glucose monitors, visual reading and urine testing
3) Insulin syringes, cartridges for the legally blind
4) Lancets and lancet auto injectors
5) Hypoglycemia rescue agents (glucose tablets and glucose paste)
6) Alcohol swabs

See Appendix A for the separate SCSD Pharmacy Benefit Manager Prescription Drug Expense Benefit program for diabetic supplies purchased at a pharmacy. Insulin and oral agents to control blood sugar are Covered under the separate SCSD Pharmacy Benefit Manager Prescription Drug Expense Benefit program.

b. Self-Management and Education (Network Provider Coverage Only). Network Benefits only are available for Diabetic self-management education and education relating to diet for you or your Eligible Dependents with a diabetic condition. Coverage is only available when rendered and billed by a Participating Provider. Coverage for self-management education services is provided for the patient when he or she is initially diagnosed with diabetes, or when the Physician certifies a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational services are limited to the following services rendered to the patient by:

1) A Physician or his or her staff during an office visit for diabetes diagnosis or treatment. When the self-management education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;
2) A certified diabetes nurse educator, certified nutritionist, or a certified registered dietician when referred by a Physician. This education may be provided in a group setting or as individual counseling. If it is found that group education is not available in your area, the Plan will cover individual education;
3) A professional Provider as described above will be Covered for services rendered in the patient's home. However, it must be decided to be Medically Necessary for the patient to receive services at home.
4) After five visits, educational services must be pre-authorized by the Claims Administrator.
17. **Aminoacidopathies Formula.** Benefits are available for certain nutritional supplements (formulas) when found Medically Necessary and administered under the direction of a Physician for the therapeutic treatment of the following Aminoacidopathies (disorders that prevent the body from properly digesting amino acids): phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. Benefits are not payable for normal food products used in the dietary management of any disorders. Refer to Appendix A for the separate SCSD Pharmacy Benefit Manager Prescription Drug Expense Benefit program for formula purchased at a network or out of network pharmacy.

**F. Miscellaneous Health Expense Coverage Provisions**

1. **Voluntary Sterilization.** Hospital, Medical/Surgical and Major Medical Expense Benefits are available for Allowable Fees relating to voluntary sterilization procedures rendered for you or your eligible Spouse. This Coverage is not available for Dependent children. Expenses related to reversal of voluntary sterilization are not Covered.

2. **Prescription Drug Expenses.**

   Medically Necessary, non-Investigational/Experimental, and FDA-approved drugs which require a prescription under Federal law are eligible for coverage under the Major Medical Expenses Benefits when supplied by and dispensed in a Physician’s office. Such drugs include, but are not limited to, injectable and intravenous medications.

   Preauthorization is also required for some injectable and intravenous drugs under the Major Medical Expense Benefits, such as Synvisc, Remicade, Lupron, and Zoladex, as well as other immune response modifiers, growth hormones, and certain chemotherapeutic regimens; contact POMCO’s pharmacy line 800-836-0709 for specific information. You may be advised to obtain a letter of Medical Necessity from your attending Physician and send it to the POMCO’s Pharmacy Case Manager for review and approval.

   **Please note:** If a prescription drug is instead obtained from a pharmacy for use in a Physician’s office, it is generally payable under the SCSD Pharmacy Benefit Manager’s Prescription Drug program. Covered prescription drug expenses, limitations and exclusions which apply to the SCSD Pharmacy Benefit Manager’s prescription drug program also apply to this Major Medical Expense Benefits prescription benefit; please refer to the separate SCSD Pharmacy Benefit Manager’s Prescription Drug program in Appendix A for details.

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<tr>
<th>Prescriptions obtained at a Physician’s office</th>
<th>Major Medical Expense Benefits</th>
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<tr>
<td>Prescriptions obtained from a retail pharmacy</td>
<td>Pharmacy Benefit Manager</td>
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See also *Chemotherapy* earlier in this Major Medical Expense Benefits section.
SECTION V - MEDICARE INTEGRATION WITH PLAN BENEFITS

If Medicare is primary, Plan benefits will be reduced by Medicare benefits. Medicare Primary plan status is determined according to Medicare Secondary Payer (MSP) rules established by government regulations. Revisions or changes in these MSP rules will automatically apply. **If you or your Dependents are eligible for Medicare primary benefits, claims should be submitted to Medicare first. Medicare explanation of benefits should be attached to your claims for this Plan.**

Please refer to the current "Medicare and You” handbook for information and details on Medicare coverage. This handbook is mailed to Medicare beneficiaries or can be obtained from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244-1850. You can telephone Medicare for information at 1-800-633-4227 or visit their website at www.medicare.gov.

You or your Dependents are responsible for Medicare enrollment. If you or your Dependent are not contacted by 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 of any age who are diagnosed with end state kidney disease or with Lou Gehrig’s disease (amyotrophic lateral sclerosis or ALS) should contact the Social Security Office and the SCSD Benefit Office for eligibility and enrollment details.**

If this Plan is primary Coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to Medicare Secondary Payer rules. Your local Social Security Office can provide details on enrollment requirements and penalties for late enrollment.

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

**A. Medicare Secondary Payer (MSP) Current Rules**

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

1. **Persons Eligible for Medicare due to age (65 and over) or Due to Disability**
   a. Medicare is secondary to the plan that covers this person as a person with active employment status or as the dependent of a person with active employment status.
   b. Medicare is primary to the plan that covers this person as a retiree or as the dependent of a retiree.

2. **Persons Eligible for Medicare due to End Stage Renal Disease (ESRD).** Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare coverage is not limited to ESRD expenses.
   a. **Medicare Eligibility Solely Due to ESRD**
      1) **30-month Rule.** Medicare is secondary for the first 30 months following the month of the ESRD eligibility date for persons eligible solely due to ESRD.
   b. **Medicare ESRD Dual Eligibility.** ESRD dual eligibility means a person who is eligible for Medicare due to age and ESRD or due to disability and ESRD. Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare benefits are not limited to ESRD expenses.
1) If a group plan is appropriately paying secondary to Medicare according to MSP rules for eligibility due to age or disability and ESRD entitlement then becomes effective, Medicare remains the primary payer. The 18-month or 30-month ESRD period does not apply.

2) If the group plan is paying primary according to MSP rules for eligibility due to age or disability and then ESRD entitlement becomes effective, Medicare remains secondary until after the 18-month or 30-month ESRD period. At the end of the 18-month or 30-month ESRD period, the group plan becomes primary or secondary payer based on the MSP rules for age and disability.

3) If a group plan is paying primary to Medicare according to MSP rules for ESRD, and then the person becomes eligible due to age or disability, Medicare remains secondary until the end of the 18-month or 30-month ESRD period. At the end of the 18-month or 30-month ESRD period, the group plan becomes primary or secondary payer based on the MSP rules for age and disability.

B. Effects of Medicare on Plan Benefits

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

1. **Medicare Payment Integration.** Medicare payment for Covered Expenses will reduce the Allowable Fees then the Plan benefit determination will be based on the balance, if any. The combination of the Medicare payment and the Plan payment will not exceed the Allowable Fees for the Covered service. If services are obtained from an Out-of-Network Provider, Allowable Fees will be reduced by Medicare payment. The balance will be subject to applicable Deductibles, percentage Copayments and other limitations of the SCSD Plan. If services are obtained from a Network Provider, Plan benefits will be based on the Network allowance. The balance will be paid in full up to the Network allowance. The Network Copayment will not apply if Medicare is primary payer for the Covered service.

   Please Note
   Plan Benefits are not available for Skilled Nursing Facility Inpatient Care even if Medicare coverage is exhausted. The Plan will not pay any related Medicare Copayments or deductibles for Inpatient Skilled Nursing Facility charges.

2. **Not enrolled in Medicare.** This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare. If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits.

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

4. **Medicare HMO.** This integration will not apply when Medicare and a Medicare sponsored HMO denies coverage due to its enrolled beneficiaries failure to abide by the HMO requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.
C. Allowable Fees

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

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

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

If you or your Dependents fail to use your primary plan HMO (including Medicare HMO) or similar plan, and that plan is primary, benefits will not be payable under this Plan. Benefits under this Plan are not payable for any expenses disallowed by any plan (including Medicare) due to the failure of you or your Dependents to follow its requirements for any benefit management procedures. Information necessary to administer the COB provision will be required when claims are submitted. You should file claims with the primary plan, then to the secondary plan with copies of their written explanation of benefits or denial.

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

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

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

### A. COB Terms and Definitions

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

1. **This Plan.** Whenever the term “This Plan” is used in this section, it means this Syracuse City School District Health Benefits Plan.

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

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

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

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

4. **Claim Determination Period.** The claim determination for coordination of benefits is done on an incurred expense basis. However, it does not include any Allowable Fees incurred during any part of a Calendar Year during which a person has no Coverage under This Plan, or any part of the year before the date this COB provision takes effect.

5. **Allowable Expense.** The term ‘allowable expense’ means a medical care expense, including Deductibles and Copayments or coinsurance, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of medical services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or services that is not covered by any of the plans will not be considered an allowable COB expense. The following are examples of expenses not considered allowable expenses or otherwise limited under this COB provision:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room and the private room is not an allowable expense unless the private room is found Medically Necessary according to This Plan’s provisions or the primary plan routinely includes coverage for Hospital private rooms.

   b. If a person is covered by two or more plans that determine benefit payments based on Usual, Customary and Reasonable (UCR) Charges, any amount more than the highest of the Usual, Customary and Reasonable (UCR) charges for the specific medical benefit is not an allowable expense.

   c. If a person is covered by two or more plans that provide benefits or services based on negotiated fees, any amount more than the highest of the negotiated fees for the specific medical benefit is not an allowable expense.

   d. If a person is covered by one plan that determines its benefits based on Usual, Customary and Reasonable (UCR) Charges and another provides benefits or services based on negotiated fees, the primary plan’s payment arrangements will be the allowable expense for all plans.

   e. The amount benefits are reduced by the primary plan because a Covered Person does not comply with the plan provisions is not an allowable expense. Examples of these provisions include, but are not limited to, mandatory requirements of a benefit management program, second surgical opinions, medical procedure review, precertification of Inpatient admissions, preapproval requirements for certain treatment, and preferred Provider arrangement.

   f. As secondary payer, long term care, dental or vision or hearing aid expenses excluded under This Plan will not be considered allowable expenses, even if such expenses were covered by the primary plan.

   g. As secondary payer, This Plan will not consider any health benefits paid due to mandatory no-fault laws as allowable expense for COB. However, charges for health expenses applied to no-fault plan Deductibles, Copayments or more than the cumulative benefit maximum per accident will be considered as allowable expenses, if otherwise Covered by This Plan.

   h. If Medicare is primary, charges more than the allowable expenses permitted under Medicare regulations will not be considered allowable expenses for COB.
B. Order of Benefit Determination

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

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

This Plan is always secondary payer to any health plans that pay without regard to coverage by other plans. This Plan is always secondary to government plans or coverages provided by federal, local, or state laws unless otherwise prohibited by that law. For example: This Plan is secondary to New York State mandatory no-fault automobile plans.

To determine the order plans should pay for expenses covered by two or more plans with a COB feature, an order of benefit determination has been established as follows:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, enrollee, or retiree is primary. The plan that covers the person as a dependent is secondary. (However, this changes if the person is eligible for Medicare primary benefits. The Medicare rules for with and without employment could apply, making the dependent’s plan primary over the plan of the person without employment status.)

2. **Child Covered under More than One Plan.** The following order of benefits is used when a child is covered by more than one plan.
   a. The primary plan is the plan of the parent whose birthday is earlier in the year if the parents are married, not separated (whether or not they have ever been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. When specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms then that plan is primary. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   c. If the parents are not married, or are separated (whether or not they have ever been married) or are divorced, the order of benefits is the plan of the custodial parent, then the plan of the spouse of the custodial parent, then the plan of the noncustodial parent and then the plan of the spouse of the noncustodial parent. The custodial parent is the parent awarded custody by a court decree. Without a court decree, it is the parent with whom the child resides more than half the Calendar Year without regard to temporary visitations.

If this Plan and another health plan's rules conflict, this Plan will use the National Association of Insurance Commissioners (NAIC) Model Regulation and any court cases to determine the validity of the conflicting rules.

3. **Active/Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired are determined before the plan that covers that person as a laid off or retired employee. The same would hold true for dependents under that person’s family coverage.
For example, for non-Medicare claims,

a. If you are eligible for SCSD Plan coverage as an active employee, and your dependent is enrolled in your family coverage but is retired or laid off from another plan, the SCSD Plan is primary for your claims and secondary for your spouse’s claims.

b. If you are eligible for SCSD Plan coverage as a retiree or laid-off employee, and your dependent is enrolled in your family coverage but also covered as an active employee under another plan, the SCSD Plan is primary for your claims and secondary for your spouse’s claims.

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

If the preceding order of benefit rules fail to establish the primary plan(s), then the plan that has covered the patient for the longer time will consider its plan benefits first.

If according to the above rules, This Plan is secondary and another health plan’s rules conflict making This Plan primary, This Plan will use the National Association of Insurance Commissioners (NAIC) Model Regulation and any court cases to determine the validity of the conflicting rules.

**C. Medicare Effect on the Order of Benefit Determination**

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

1. For individuals eligible for Medicare due to age (65 or over) or due to disability who are covered under a plan as a person with current employment status, or a dependent of a person with active employment status, the following order of benefit determination applies:
   a. All active plans, active employees and their Eligible dependents, pay first.
   b. Medicare pays second.
   c. Retired plans pay last.

2. For individuals eligible for Medicare solely due to End-Stage Renal Disease (ESRD), the order of benefit determination is as follows:
   a. Medicare pays last for the first 30 months following the month of first eligible End-Stage Renal Disease treatment. Usual order of benefit determination would apply for other group plans.
   b. Medicare pays first after the first 30 months. Other plans would be secondary following the order of benefit determination.

**D. COB Effect on Plan Benefits**

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

When This Plan is secondary, payment could be reduced if the benefits available for the Covered Expenses under This Plan (without this COB provisions) and the benefits payable by all other involved plans are more than 100%, then the benefits of This Plan will be reduced so that they, and the benefits payable under the other plan(s), do not total more than the total allowable expenses incurred during a claim determination period. When the benefits of This Plan are so reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.
If a person is eligible for Medicare primary coverage according to Medicare secondary payer rules and is not enrolled in Medicare Part A and/or Part B or in Part C, then Medicare benefits will be estimated. The estimated Medicare payments will be used to determine the benefit reduction under this COB provision.

**E. Right to Receive and Release Needed Information**

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

**F. Facility of Payment**

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

**G. Right of Recovery**

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

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

**H. Examples of COB Order of Benefits**

1. I am eligible for SCSD Plan benefits as an active Employee and am also eligible as a retiree under the ABC Mfg. health plan. (I am not eligible for Medicare). Which plan pays first?
   
   *Your active Plan with SCSD is primary over your retired plan. The SCSD plan would pay first.*

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

   **Health Claims for yourself:**  
   The SCSD retired Plan pays first.  
   XYZ, Inc. active plan pays second.

   **Health Claims for Spouse:**  
   ... XYZ, Inc. active plan pays first.  
   ... The SCSD retired Plan pays second.

3. I am eligible for SCSD COBRA Continuation. My Spouse covers me as a dependent under her employer's health plan. My Spouse is an active employee of XYZ, Inc. I am not eligible for Medicare due to age or disability. Which plan pays first for my health claims? For my Spouse's health claims? For my children's claims.

   *Continuation of coverage is secondary to other plans. The order of benefit determination for you, your Spouse and your children is:*  
   XYZ, Inc. active plan pays first.  
   The SCSD COBRA continuation pays last.

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

**Health Claims for you.** Your Health plan would pay before the health plan of your Spouse. Order of benefit determination is:
- The SCSD active Plan pays first.
- ABC Mfg. retired plan pays second.
- XYZ Inc. active plan for Spouse pays last.

**Health Claims for Spouse.** Your Spouse's plan pays before your health plans. Order of benefit determination is:
- XYZ Inc. active plan for Spouse pays first.
- The SCSD active Plan pays second.
- ABC Mfg. retired plan pays last.

**Health Claims for Dependent Child.** The order of benefit determination is based on the earliest birthday (month/day) of the child's parents. The plan(s) of the parent with the earliest birthday pays before the plan(s) of the parent with the later birthday. As your Spouse's birthday (June 15) is the earliest date, the order of benefit is:
- XYZ Inc. active plan of Spouse pays first.
- The SCSD active Plan pays second.
- ABC Mfg. retired plan pays last.

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

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

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

6. I am eligible for SCSD benefits as a retiree and I am also eligible for Medicare benefits due to age. In addition, I am eligible for benefits as a dependent under my Spouse's health plan through her/his employer, XYZ Inc. My Spouse is an active employee. Who pays first?

*The order of benefit determination rules can change due to Medicare rules. According to Medicare Secondary Payer rules, Medicare pays after active (with employment status) employee plans for persons eligible for Medicare due to age or disability. The active plan(s) covering a person as an employee or a dependent must pay before Medicare. The order of benefit for health claims on you would be:*
- XYZ active plan of Spouse would pay first
- Medicare would pay second
- SCSD retired Plan would pay last.

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

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

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

*The order of benefit determination after 30 months would be:*
Medicare pays first.
XYZ Inc. Spouse's plan pays second.
SCSD Plan pays last.
SECTION VII - CLAIM SUBMISSION AND REVIEW PROCEDURES

A. How to Obtain Benefits / Claim Submissions

If Medicare or another health plan is the primary plan, claims should first be submitted to those plans and then to POMCO with copies of their explanation of benefits or denial. Claims for conditions due to occupational cause, automobile accident or incident; or when benefits could be available under another insurance or similar plan not owned by you or your Dependents should be submitted to the other plan or insurance company. If benefits denied, bills should be sent to POMCO with a copy of the other coverage denial letter. Be sure to advise the Provider of these situations to avoid overpayment of Plan benefits.

1. Network Provider Claims. A POMCO Network Provider will bill POMCO directly for benefits. You or your Eligible Dependent need only present your POMCO identification card to confirm Plan eligibility and complete any information requested by the Provider. Be sure to give the Network Provider full information on other health plans and history of any Accidental Injuries.

2. Hospital Inpatient or Outpatient Claims. Usually, the Hospital will mail claims directly to POMCO. If you are billed directly, follow the instructions for Other Claims Submissions shown below. If you or your Eligible Dependents are covered by more than one plan, the Hospital will usually bill the plans according to standard Medicare or COB order of benefit determination rules. Example: If Medicare is primary, the Hospital will first bill Medicare and then POMCO for any balance. Be sure to provide information concerning all health coverage to help proper billing.

3. Prescription Drug Claims. Refer to the separate SCSD Pharmacy Benefit Manager Health Prescription Drug program in Appendix A for details on how to obtain benefits.

4. Other Claim Submissions. If Medicare is primary for medical services or supplies, the Provider will usually bill Medicare directly. All you need to do is provide the necessary information to enable the Provider to submit to Medicare. The Provider may then bill you or POMCO directly. If you are billed for Covered Services, you must take the following steps to submit a claim for benefits:

   a. Claim forms should be obtained from SCSD Benefits Office or from POMCO. Be sure to read the instructions printed on the claim form. Remember: You must attach a completed claim form each time you send in medical bills and a separate claim form is needed for each family member.
   b. Once you have completed your portion of the claim form, the Doctor can complete his portion, if needed, or you may attach itemized bills. If an itemized bill is attached, it must clearly state the patient's name, diagnosis, full description of service rendered and an itemized list of charges with dates of service.
   c. The bill should also include the Provider's signature and tax identification number. Any bill from a nurse must show the date, place and hours of duty, charge per hour, total charge per day and signature, credentials and registration number.
   d. If services are due to a Non-occupational or other Accidental Injury, you must provide complete details on how, where, the date, and the time such Injury was sustained. If Injury was sustained at a place other than your place of residence, a third party verification form should be obtained from the SCSD Benefits Office and completed by you. The completed form should be mailed to POMCO with your initial claim to avoid delay in determination of benefits.
   e. Attach Medicare or other plan explanation of benefits or denial, if appropriate.
   f. All completed forms and itemized bills should be submitted to:

   POMCO
   P.O. BOX 6329
   SYRACUSE, NY  13217-6329
The Claims Administrator will accept other valid claim forms that provide the necessary information to decide Coverage. If you fail to provide necessary information, your claim will be returned to you to provide missing information or additional details may be requested which could delay the determination of Plan benefits. POMCO will advise you of the approval or rejection of your claim by mail.

B. Time Limit on Claim Submission

Claims should be submitted as incurred. However, to be considered for benefits, claims must be submitted (postmarked) to POMCO within 90 days (March 31) following the Calendar Year in which the Covered Expenses were incurred. This time limit may be extended when this Plan is secondary and POMCO receives the claim within 90 days after the date of the other plan's explanation or denial. This extension will not apply if the other Plan denies the claim for late submission based on their late filing time limit.

C. Payment of Benefits/Authorization to Pay Provider

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

Hospital Expense Benefits are paid directly to the Hospital or other facility, if you have not already paid charges. Participating Provider benefits are also paid directly to the Network Provider. All other health benefits are generally paid directly to you unless you sign the authorization on the appropriate section of the claim form to have payment made directly to the Provider. A separate claim form should be used for each Provider to whom you want direct payment made.

The Plan may, at its option, elect to pay benefits directly to the Provider or other entity, if appropriate. Without Provider tax identification information the Plan may, at its option, reimburse benefits to you rather than the Provider, even if you authorized benefit payment to that Provider. A separate claim form should be used for each Provider to whom you want direct payment to be made.

In the case of your death, the Plan may elect to pay benefits to any unpaid Provider, your estate, your Spouse, your parents, your children or your brothers and sisters as deemed appropriate.

D. Health Claim Inquiries

When you have any questions concerning your Coverage, you may phone the SCSD Benefits Office or phone POMCO at their local # (315) 432-5567 or phone toll-free at 1-800-358-8399.

E. Claim Appeals Procedure

If a claim for benefits is denied in whole or in part, you may appeal the claim determination to the Claims Administrator. Your appeal must be in writing and mailed to the Claims Administrator within 60 days from the date of written denial. The Plan reserves the right to maintain denial of benefits without further review for any appeals received more than 60 days after the initial notice of claim denial. POMCO will advise you of the results of their appeal review. Your written appeal should be mailed to:

POMCO
Appeals Unit
PO Box 6329
Syracuse, NY 13217-6329
F. Legal Proceedings

No action at law or inequity 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 VII of the Plan, nor shall any such action be brought at all unless commenced within two years from the date the Covered service or supply was incurred. However, in the event this self-funded Plan is being terminated and the Covered Person is notified of the termination, 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 termination. Any lawsuit brought under the Plan shall be construed and enforced in accordance with the laws of New York, both as to construction and interpretation.
SECTION VIII - OTHER PROCEDURES AND PROVISIONS

A. Not a Contract

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

B. Verification of Claim Information

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

C. Right of Examination

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

D. Indemnity Benefits

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

E. Misrepresentation/Fraud

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

F. Refund Due to Overpayment of Benefits

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

This Plan specifically does not provide any Coverage with respect to any Injury or Illness for which a third party may be liable or legally responsible. If you or your Dependent receives payment or expects payment from a third party insurance, surety or other type plan for medical expenses resulting from such Injury or Illness, you should not submit a claim under this Plan for such medical expenses. Any Plan benefits paid against such claims will be considered an overpayment. The Plan will exercise its right to full reimbursement for resulting overpayments. However, if for some reason the third party claim payment or settlement is expected to be delayed for an extended time, the Plan Administrator may, at its option, authorize Plan benefits for medical expenses that would otherwise be Covered by this Plan. The rules shown below govern how this Plan pays benefits in such situations.

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

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

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

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

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

The Plan reserves the right to deny benefits for any charges that are or could be considered subject to the Plan’s right of subrogation in the case of failure by you and/or your Eligible Dependent or legal representative to comply with the above conditions.

**H. Amendments or Cancellation of the Plan/Right to Develop Guidelines**

The Plan Administrator, in its sole discretion, reserves the right to amend, reduce, revise or cancel any or all of the benefits, limitations, provisions, inclusions or exclusions of the Plan unless specifically precluded under the terms of any applicable bargaining agreement entered into between SCSD and affected union(s). If the Plan cancels, Coverage will end for all persons enrolled under the Plan. The Plan Administrator reserves the right to develop or adopt criteria which clarifies in more detail the procedures and circumstances for which expenses for medical services and supplies may be approved within the limitations and exclusions of this health Plan.

**I. Construction**

This Plan shall be governed and construed according to Federal regulations and the regulations of the State of New York to the extent not preempted by federal regulations, and to the extent such federal and state regulations are directed at this type of Plan.

**J. Severability**

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

**K. Waiver and Estoppel**

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

**L. Headings**

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

**M. HIPAA Privacy**

The federal Health Insurance and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality 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. 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.
SECTION IX – EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Syracuse City School District recognizes that alcoholism and substance abuse are chronic diseases that can affect an individual at any age. To assist and encourage Rehabilitation of these diseases, the School District has established an Employee Assistance Program for Employees and Eligible Dependents. In addition, should you or your Eligible Dependent need assistance for mental health Illness or for family and other life circumstance problems, the EAP may be able to help you.

A. EAP Eligibility

To be eligible for benefits under this program:

1. You or your Eligible Dependent must contact the SCSD Physician or the EAP coordinator at SCSD to establish an approved EAP Plan of Care.

2. Either the SCSD Physician or the EAP coordinator must make referral and approval for any EAP service. Approval of the care plan can also be made by the EAP Claims Administrator (POMCO) after referral by the SCSD Physician or EAP coordinator.

3. The Provider(s) of service must be accredited and approved by the SCSD Physician, EAP coordinator or the EAP Claims Administrator.

4. The individual who is being treated for alcohol, substance or other addictions must agree to mandatory attendance at meetings of an organization devoted to therapeutic Rehabilitation support, such as Alcoholics Anonymous.

B. EAP Covered Services

The EAP Coordinator can advise you on EAP benefit limits. Although EAP services may be coordinated with the SCSD Health Benefit Plan for payment purposes, the EAP is separate from the Health Benefit Plan and is not subject to the Health Benefit Plan provisions and exclusions. Allowable Fees will be paid for an EAP Approved Plan of Care rendered for you or your Eligible Dependent for the following services:

1. Alcohol/Substance Abuse Care - Outpatient. Services rendered and billed by an EAP approved Provider for the diagnosis and treatment of alcohol or drug addiction on an Outpatient basis are Covered. Note: The SCSD Health Benefits Plan shown previously in this SPD provides Coverage for Inpatient and Outpatient care. Please refer to Section I - Summary of Benefits, Section III - Benefit Management Program and Section IV - Covered Services for additional information on Plan Coverage and limitations.

2. Mental Health/Life Circumstance Problems. Services rendered and billed by an EAP approved Provider for Psychiatric Care or other counseling for treatment of a Mental Illness or for assistance on family problems and other life circumstances are Covered.

3. Smoking Cessation. EAP offers limited Coverage for smoking and other tobacco related problems including counseling and smoking deterrent aids and drugs.

C. Confidentiality

All referrals, dealings and medical documents relating to you or your Dependent's participation in this program are kept strictly confidential by the SCSD Physician, the EAP Coordinator and the EAP Claims Administrator.
D. EAP Inquiries and Participation Requests

The School District EAP coordinator can be reached at (315) 435-4538 should you or your Eligible Dependent want detailed information on how EAP can help with problems shown above.
APPENDIX A

Prescription Drug Program

Syracuse City School District
Health Benefits Plan

(A self-funded program for Employees and Retirees of SCSD)
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INTRODUCTION
Claim Administrators: Medco for Network Pharmacy and Mail Service Prescription Benefits

Please Note
This appendix clarifies, updates and replaces previous Plan documents or other publications concerning coverage and benefits for the self-funded Syracuse City School District Prescription Drug Benefits Program. It is a restatement of Program benefits in effect as of July 1, 2006. The pronoun you or your means an eligible and enrolled Employee or retiree of the Syracuse City School District. It also means a survivor Spouse or COBRA participant whose Social Security number is used for Plan enrollment. Terms throughout this document have been capitalized and are defined in Appendix B - Definitions to help you understand your Plan Coverage and benefits.

The Plan Administrator, Syracuse City School District, provides a pamphlet to eligible and enrolled employees and retirees that shows the following description of the Program. This pamphlet is not intended to interpret, extend, or change the provisions of the Plan in any way.

The provisions of this Plan may only be determined accurately by reading the Master Plan Document, Amendments and other documents concerning the terms of the Plan. To the extent the employees’ handbook or other Plan information is inconsistent with the provisions of the Master Plan Document, the terms of the Master Plan Document will govern. The Master Plan Document, the terms of the Plan and any Amendments to the Plan, are maintained and on file with the Plan Administrator.

Plan benefits are self-funded and paid by the Syracuse City School District. Medco has been engaged by the District to act as the Claims Administrator on the District’s behalf and to handle the Pharmacy Benefits Administration.

Prescription Drug Administrator

Medco administers the Prescription Drug Program on behalf of Syracuse City School District. If you have any questions or concerns about your Coverage, you can phone the Syracuse City School District or the Member Services at Medco at 1-800-711-0917. To reach Medco’s Special Care Pharmacy, you can phone 1-800-939-2108. Claim forms can be obtained from your Benefits Office or from Medco’s Member Services or www.medco.com. Refer to Section VII - Claim Submission and Review Procedures for details on how to submit a claim.

Medco
Post Office Box 14711
Lexington, Kentucky 40512
Toll-free: - 800-711-0917

1. Network Pharmacy. If this Plan is primary payer for prescription drug benefits, Medco administers claims for Network pharmacy benefits. If this Plan is a secondary payer for prescription drug benefits, claims must be submitted to POMCO for coordination of benefits. Refer to Introduction of Master Plan Document and Summary Plan Description for Syracuse City School District Health Benefits Plan. Mandatory generic substitution and Copayments apply. Long term or maintenance drugs must be obtained through the mail service pharmacy. Refer to Section III - Covered Services under Prescription Expense Benefits for details on how to obtain benefits.

2. Mail Service Prescription Benefits. If this Plan is primary payer for prescription drug benefits, Medco Health administers the mail service program for maintenance drugs. This program is not available if this Plan is secondary payer for your prescription drugs. Refer to Section III - Covered Services under Prescription Expense Benefits for details on how to obtain benefits.
SECTION I - SUMMARY OF BENEFITS

The benefits shown in this document are available to eligible and enrolled Employees, retirees and their eligible and enrolled Dependents (Covered Persons).

Please Note
All claims are subject to review to determine whether or not services are Covered in accordance with plan limitations. You must comply with requests for additional medical documentation as deemed necessary to evaluate a claim for benefit payment. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. The patient’s Physician is responsible for determining whether treatment should be rendered regardless of whether the charges are totally or partially included in, or excluded from, Coverage under this Plan.

A. Prescription Drug Expense Benefits

Mail Service Pharmacy must be used for maintenance drugs, except Schedule II or Schedule IV class of drugs (i.e. prescriptions that require NY triplicate drug form). See Section III - Covered Services under Prescription Drug Expense Benefits for details. Out of Network benefits apply to Acute Care drugs when this Plan is secondary payer according to COB order of determination rules. See Section VI - Coordination of Benefits in Health Benefits Plan Summary Plan Description.

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<tr>
<th>Covered Prescriptions</th>
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<th>Out of Network</th>
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<tr>
<td>Retail</td>
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<tr>
<td>Acute Care Drugs (Limited to 30-day supply plus one 30-day refill)</td>
<td>Network Copayment: $2.00 per each Generic Drug</td>
<td>Out of Network Copayment 25% Copayment</td>
</tr>
<tr>
<td>Mandatory Generic Drug Substitution Applies.</td>
<td>25% Coinsurance of Brand Preferred or Brand Non-Preferred cost.</td>
<td>Plan pays 75% of Usual, Customary and Reasonable allowance. Deductible and Percentage Copayment limits do not apply.</td>
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<td></td>
<td>If Generic is available for Brand Preferred or Brand Non-Preferred, Member pays 25% of drug cost plus difference in cost in Brand and Generic.</td>
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<tr>
<td></td>
<td>Plan pays balance of Network Costs.</td>
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<tr>
<td>Mail Order</td>
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<tr>
<td>Mail Service Pharmacy/ Maintenance Drugs</td>
<td>Current contractual Copayment amounts apply.</td>
<td>Not a Covered Benefit</td>
</tr>
<tr>
<td>Mandatory Generic Drug Substitution Applies.</td>
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</table>
B. Potential Causes for Benefit Reduction


If you or your Dependent should enroll in Medicare Part D upon eligibility, it will result in significant reduction or denial of your prescription drug benefits. If you are enrolled in the SCSD Prescription Drug Program, you should not elect to participate in Medicare Part D.

Beginning January 1, 2006, Medicare Modernization Act (MMA) provides Medicare beneficiaries access to prescription drug coverages. This prescription drug benefit is commonly referred to as Medicare Part D. All Medicare beneficiaries - no matter how they receive their health care today or whether they have existing drug coverage - will be eligible for drug coverage under a Medicare prescription drug plan.

A Plan is required to determine whether or not its coverage is considered creditable. If its actuarial value equals or exceeds the actuarial value of standard prescription drug coverage under the Medicare prescription drug benefit, the plan is deemed ‘creditable’. In general, this actuarial equivalence test measures whether the expected amount of paid claims under the plan sponsor’s prescription drug coverage is at least equal to the expected amount of paid claims under standard prescription drug coverage under Medicare.

It has been determined that the Prescription Drug Program offered by SCSD is creditable.

MMA guidelines are subject to change. You will be notified of any related changes that will affect your prescription drug coverage.
SECTION II - ELIGIBILITY AND ENROLLMENT

Eligibility for Plan Enrollment

SCSD’s Prescription Drug Program is available to Employees, Retirees and their dependents in coordination with their enrollment in the Medical Plan to provide coverage for the costs of prescription medication.

Eligibility for Prescription Drug Program coverage is based upon enrollment in the SCSD Medical Plan. Refer to Section II of Syracuse City School District Health Benefits Plan Summary Plan Description for eligibility details. You and your eligible dependents automatically receive Prescription Drug Program coverage upon enrollment in SCSD’s Medical Plan. Your Prescription Drug Program coverage will be effective on the date that your Medical Plan coverage is effective.

SECTION III - COVERED SERVICES

The following pages provide details of your Coverage. Covered Services are subject to Plan limitations and exclusions. See Section I - Summary of Benefits for information on benefit limits and Appendix C - Plan Exclusions for details on expenses not Covered, and Appendix B - Definitions for more information concerning terms that may apply to the Plan.

1. Medical Supplies (Self-Care Home Use). Benefits are available for certain medical supplies for self care home use when ordered by an attending Physician and found Medically Necessary according to Plan provisions. Medical equipment may be covered under the Medical or Prescription Drug benefit plan. Under the Prescription Drug Program, Coverage is limited to the following medical supplies:
   a. Syringes and needles necessary for conditions such as diabetes. See Diabetic Supplies, Equipment and Education shown later in this section.
   b. Glucagon emergency kits

2. Diabetic Supplies, Equipment and Education. Benefits are available for diabetic supplies and equipment ordered by a Physician for you or your Eligible Dependents. Supplies or equipment must be found Medically Necessary, according to Plan provisions, for the treatment of diabetes. Coverage for this benefit is limited to the following items:
   a. Insulin syringes, cartridges for the legally blind
   b. Hypoglycemia rescue agents (glucose tablets and glucose paste)

See Prescription Drug Expense Benefits shown later in this section for diabetic supplies purchased at a pharmacy. Insulin and oral agents to control blood sugar are Covered under the Prescription Drug Expense Benefits.

A. Prescription Drug Expense Benefits
The Network Pharmacy and Mail Service benefit does not apply if this Plan is secondary according to the COB order of benefit determination. Out of Network benefits would apply. See Section VI - Coordination of Benefits in Health Benefits Plan Summary Plan Description. If this Plan is secondary and network or mail service benefits are obtained, you will be responsible for reimbursement of any overpayments. However, if this Plan is considered the primary payer and Network pharmacies or the Mail Service are used for drug purchases, you save costs for yourself and your employer, SCSD.

Benefits are available for drug or medicine and insulin expenses incurred by you or your Eligible Dependents when ordered by a Physician and found Medically Necessary for treatment of Illness or Injury according to Plan provisions. Prescription drug benefits are not provided for any drugs (except insulin) that can be obtained without a Doctor’s prescription. Drug expenses will be reimbursed based on the Acute Care Drug Program and the Mandatory Maintenance Drug Program requirements shown below.

1. Acute Care Drug Program

   a. Network Pharmacy. A participating network pharmacy has an agreement with the prescription benefit manager, to accept the Plan benefit, after any applicable Copayment, as payment in full. If this Plan is the primary payer, you or your Dependents may purchase Covered drugs at any pharmacy, however, your costs will be higher if a non-network pharmacy is used. If a Covered drug is purchased at a participating pharmacy, you will be required to pay the Copayment amounts and any additional costs resulting from the Mandatory Generic Substitution requirement shown later in this section.

   1) Network Copayments or Coinsurance. You must pay the following Copayment or Coinsurance. Then, the Plan will pay the balance of allowable charges:

   - $2.00 for each Generic Drug
   - 25% of Allowable Fees for each brand name drug

   2) Obtaining Network Benefits. You or your Dependents can use your Plan identification card at any Medco participating network pharmacy. You may also phone Medco Member Services at 1-800-711-0917 for participating pharmacy information.

   To obtain your Covered drugs at the participating network costs, you need only present your Plan identification card and the written prescription to the pharmacy, then pay the applicable Copayment amount. The pharmacy will bill Medco directly and receive direct payment from them. If you do not present your Plan identification card at the time of purchase, you must file your own claim and benefits will be allowed as if the drugs were purchased at a nonparticipating pharmacy. Refer to Nonparticipating Pharmacy shown later in this section.

   Questions or concerns about the network drug program can be answered by Medco. You may contact them by calling their customer service department anytime (24 hours a day, 7 days a week, including holidays) or by sending a written inquiry to:

   Medco Health
   P O Box 2187
   Lee’s Summit, MO 64063-2187
   1-800-711-0917

   b. Mandatory Generic Drug Substitution. In accordance with the New York State Medicaid Mandatory Generic Drug Program (Department of Health Medicaid Update October 2002, Volume 17, Number 11), it is mandatory that Generic Drugs are substituted for brand name drugs whenever appropriate for your condition. Since Generic Drugs typically cost less than brand name drugs, you save money for yourself and the Plan.
when you substitute the lower priced drug. Benefits will continue to be paid for brand-name drugs which have no generic equivalent. However, when a prescription is written for a brand-name drug and a Generic Drug is available or the Doctor fails to support medical reason for no generic substitution, Plan payment will be limited to that of the generic equivalent.

1) **Non-compliance Benefit Reduction.** If you or your Eligible Dependent receives a brand drug when a generic substitution is available, and your physician has not provided documentation indicating the need for a brand name drug, you are responsible for paying the difference between the cost of the brand name drug and the Generic Drug plus the applicable Copayment. Drug costs will be based on participating pharmacy prices established by Medco. This could result in substantial payment by you due to significant difference in costs between the more expensive brand name drug and the less expensive Generic Drug.

2) **Appeal for Mandatory Drug Requirement.** If your Doctor feels there is a Medically Necessary reason why you must have the brand-name drug instead of its generic equivalent, you can request an appeal of the Mandatory Generic Substitution requirement by completing a generic appeal form. You and your Doctor would complete this form and submit it to Medco for review. If approved, Medco will allow the brand name drug. If not approved, a second step appeal may be filed with the Claims Appeal Committee. See Section VII – Claims Submission and Review Procedures for more information.

c. **Nonparticipating Pharmacy (Out of Network)**

| Out of Network Benefits apply when acute care drugs are purchased at a nonparticipating pharmacy, when this Plan is secondary payer, and/or when you fail to use your Plan identification card. |

Out of Network pharmacy purchases are Covered with a 25% member copayment. The claims are processed by Medco and the Plan pays 75% of Allowable Fees. Allowable Fees will be based on the Usual, Customary and Reasonable (UCR) charges for your prescription drugs. If this Plan is primary, the mandatory mail order and mandatory generic replacement rules shown previously apply even if a nonparticipating pharmacy is used.

You will be responsible for the payment of charges more than the Usual, Customary and Reasonable allowance plus the 25% percentage Copayment balance not paid by the Plan. If a brand name drug is purchased instead of generic replacement, you will also be responsible for payment of the charges more than the Usual, Customary and Reasonable cost of the generic replacement.

1) **Obtaining Out of Network Benefits.** If you or your Eligible Dependents purchase acute care drugs (generic or brand name), at a nonparticipating pharmacy or do not use your Plan identification card at a network pharmacy, you must pay the pharmacy the full cost of the drug then submit a claim to Medco. If this Plan is secondary payer, you must also submit the other Plan explanation of payment or denial. (Maintenance drugs must be filled through the Mail Service pharmacy and are only covered when filled through Medco’s mail order pharmacy). Refer to Section VII - Claim Submission and Review Procedures for information on how to submit out-of-network claims.

*To file a claim for benefits*, you must obtain a health claim form from your Benefits Office or by contacting Medco at 1-800-711-0917 or by accessing their website at www.medco.com. The original drug receipt (receipt should include date of purchase, name of drug, dose and Rx #) and the completed health claim form should be mailed to:

Medco  
P.O. Box 14711  
Lexington, KY  40512
2. **Mandatory Mail Maintenance Drug Program.** When this Plan is primary, you must obtain maintenance drugs through the Mail Service to be eligible for Plan benefits. Maintenance drugs are medications which are taken for chronic conditions. Examples of maintenance medications are drugs for the treatment of hypertension, heart disease, and diabetes. In addition, acute care medications written for more than 30 days (one refill) must be obtained through the Maintenance Drug Program. Maintenance prescription drugs will be mailed to your home by using Medco Health, the mail service pharmacy. *A Copayment is required when drugs are obtained through the Maintenance Drug Program.* The Plan pays the Mail Service Pharmacy in full for drugs obtained through them. Members may receive the first two fills (for one month supply each at a retail pharmacy, and all subsequent medications must be filled through Mail Service).

a. **How to Use the Mail Service Pharmacy Program**

1) When your Doctor writes a prescription for a "maintenance drug" (one taken regularly or on a long-term basis) ask him/her to indicate the number of refills allowed. When using Medco by Mail, be sure to ask your doctor to write a prescription for up to a 90 day supply of each medication (plus refills for up to one year, if appropriate).

2) For your first mail service order, complete the patient profile/registration form. Enclose in the reply envelope the original prescriptions written by your Doctor and mail. Patient profile/registration forms may be obtained by contacting your Benefit Office. Your physician can also phone 1-888-EASYRX1 for instructions to fax a new or renewal prescription. Or, you may access Medco’s website at [www.medco.com](http://www.medco.com) to obtain information.

3) For refill prescriptions, complete the order form supplied by Medco and included with each delivery. You may also order refills through their website [www.medco.com](http://www.medco.com) or phone 1-800-4refill.

4) Your medication will be delivered to you by first class mail or other carrier. You should allow 7-11 days from the time you mail your prescription forms to Medco until the delivery of your medication. To ensure that you have an adequate supply of medication, you will be best protected if you order when you have a minimum of a three-week supply of your current medication.

b. **Mail Order Copayments**

Current contractual copayments apply. Refer to your collective bargaining contract for details.

3. **Covered Prescription Drug Expenses**. Prescription refills will be paid for up to one (1) year from the date of the original prescription. Unless otherwise excluded, Allowable Fees for the following drugs and supplies are eligible for Plan benefits when found Medically Necessary according to Plan provisions and when used for approved therapeutic application:

a. Oral and certain injection medications that require a prescription by a licensed Physician and are Federal legend drugs.

b. Compounded medications containing at least one Federal legend drug in therapeutic amount.

c. Prescription Drug Vitamins, including Prenatal prescription vitamins.

d. Birth Control drugs when approved for treatment of identifiable organic Illness.

e. Insulin and insulin syringes.

f. Topical Vitamin A derivatives (example: Retin-A) to the age of 35. Preauthorization by Medco required for persons 35 and older.

g. Disposable needles and syringes needed for Covered injectable prescription drugs.

h. Allergy emergency kits for emergency treatment of insect stings in allergic patients.

i. Antimigraine agents, e.g., Imitrex, which may be limited to certain monthly quantities in accordance with FDA and manufacturer recommended dispensing limits. Dispensing limits may apply.
4. **Preauthorization Requirements.** Some drugs require preauthorization before benefits become available. The network or mail order pharmacy will not pay unless the following drugs have been approved for benefit payment. The following is a partial list of drugs that require preauthorization. *If the pharmacy advises that you need preauthorization, ask your attending Physician to contact Medco at 800-753-2851. These include, but are not limited to, drugs such as Retin A, Lupron or Zoladex, birth control drugs, growth hormones, immune response modifiers (Betaseron), biotech drugs (e.g. copaxone). Benefits will become available based on Medco’s review and approval.*

5. **Dispensing Limits.** For certain drugs, the plan normally provides coverage up to specified dispensing limits. These dispensing limits are established by physicians, including board certified and nationally respected physicians, clinical pharmacists and others. Pharmaceutical manufacturer and FDA guidelines are also used in determining dispensing limits. Physicians are usually acquainted with these procedures, and pharmacists normally check with physicians when the pharmacist has a reason to want to assure prescription accuracy, even if obtaining this assurance may delay immediate filling of a prescription.

6. **Prescription Drug Expense Exclusions.** Exclusions listed under Plan Exclusions also apply unless expenses are specifically included for benefits under this title, Prescription Drug Expense Benefits. In addition to limitations shown otherwise in the Plan, the following drugs or supplies are NOT Covered under Prescription Drug Expense Benefits:

   a. Non-Legend drugs/over the counter (drugs obtainable without prescription). Exception: Drugs specifically included for Coverage under this benefit.
   b. Extemporaneously prepared combinations of raw chemicals or combinations of federal legend drugs in a non-FDA approved dosage form.
   c. Weight loss drugs, anti-obesity/appetite suppressants.
   d. Contraceptives, medicines, drugs, or devices used for birth control. Exception: Birth Control pills preapproved for treatment of identifiable organic Illness.
   e. Infertility or fertility medications, impotency drugs, Viagra or similar drugs. Exceptions would be instances of lifestyle drugs being used for approved therapeutic application. Example: Viagra used for medical condition Pulmonary Arterial Hypertension.
   f. Implantable time release medication (i.e. Norplant)
   g. Therapeutic/diagnostic devices and appliances. Coverage may be available for Physician services under Medical Plan.
   h. Drugs FDA approved for cosmetic use only or other drugs used for cosmetic purposes including, but not limited to hair growth medications such as Rogaine or Minoxidil.
   i. Investigational or Experimental drugs; or drugs prescribed for Experimental (non-FDA approved/unlabelled) indications.
   j. Immunization agents, vaccines, allergy extracts and blood or plasma. Coverage may be available for Physician services under Medical Plan.
   k. Fluoride products.
   l. Vitamins dispensed without a prescription, minerals, food supplements or nutritional products even if ordered by a Doctor. Exception: Prenatal prescription vitamins used during maternity care or other prescription drug vitamins.
   m. Charges for the administration of any medication (these charges may be covered under the Medical Plan).
   n. Smoking deterrents such as patches, gum, drugs, or similar even if prescribed by a Physician. (SCSD offers limited Coverage for smoking cessation counseling and aids under the Employee Assistance Program).
   o. Drugs or supplies furnished by home health care agencies, hospice care agencies or by Hospitals, skilled nursing facilities, convalescent facilities, rehabilitation facilities or other facilities while the patient is confined. These drugs and supplies are considered part of the services provided by the facility and are not Covered under the Prescription Drug Expense Benefits (these charges may be covered under Medical Plan).
   p. Drugs that are not considered Medically Necessary for treatment of an Illness or Injury even if obtainable
only by prescription and even if prescribed by a Physician.

SECTION IV - COORDINATION OF BENEFITS (COB)

Refer to Syracuse City School District Health Benefits Plan Summary Plan Description.

SECTION V - FORMULARY

A formulary is a list developed by an independent panel of physicians and pharmacists that contains preferred medications approved for coverage. The drugs on the list are chosen based on comparative clinical effectiveness, safety profiles and opportunities to help contain costs. This list is maintained by the Plan’s Pharmacy and Therapeutics Committee for use under the Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically and is therefore subject to change. If not otherwise excluded, the Formulary includes all Generic, Preferred and Non-Preferred Drugs. For a complete listing of drugs, you may access medco.com. Plan Exclusions still apply.

1. Definitions (also in Appendix B).

a. **Generic Drugs** — A drug available only upon the written prescription of a Physician, used for the treatment of an Illness or Injury. A generic drug is the chemical equivalent of a drug that has an expired patent. When a brand name drug’s patent expires, other pharmaceutical companies can produce the same active chemical compound and sell the drug under its generic name. In the United States, the Food and Drug Administration (FDA) requires that all drugs, whether a brand name drug or a generic drug, meet standards of safety, strength, purity and effectiveness. A drug may be chemically exact but not bioequivalent. In other words, two different products of the same drug may not be absorbed into the body in exactly the same way. Bioequivalence depends on how the drug is formulated and how it is absorbed and eliminated by the body. Other ingredients can affect the absorption of the drug. These include starch fillers, gum-like substances and other products which allow a drug to be formulated into a pill or capsule. Factors such as a person's age, body mass, kidney, liver and intestinal function can also affect the absorption of the drug by the body.

b. **Brand-Preferred Drugs** - FDA approved drugs under patent to the original manufacturer and only available under the original manufacturer’s branded name. Brand-name drugs are generally given patent protection for 20 years from the date of submission of the patent, therefore a generic drug is not available. This provides protection for the innovator who laid out the initial costs (including research, development, and marketing expenses) to develop the new drug. They are referred to as “Tier 2” drugs and include the majority of brand name drugs available today. Brand-name drugs are patent-protected and product-trademarked.

c. **Brand Non-Preferred Drugs** — These are typically newer or highly advertised drugs, which are also referred to as “Tier 3” drugs. Many of these drugs have a lower cost brand or generic available. These drugs are determined by the Plan’s Pharmacy and Therapeutics Committee as being duplicative or as having Preferred Drug alternatives available. Benefits are provided for Non-Preferred Drugs; however, copayments will be higher than for Preferred Drugs.

2. **Changes to the Formulary.** Regularly scheduled changes that result in brand-preferred drugs becoming
non-preferred occur twice annually. However, there may be changes to the formulary more than twice annually for the following reasons: a drug may be removed from the market due to safety reasons; or generic alternatives may become available which may result in a brand-preferred drug becoming non-preferred.

3. **Notification of changes to the Formulary.** A letter will be sent to individuals taking one or more of the drugs changing to a Brand Non-Preferred status. A letter will be sent regardless of the type of drug (maintenance or acute).

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## SECTION VI - PLAN EXCLUSIONS

All benefit determinations are based on Plan limitations and exclusions in effect at the time expenses are incurred. All claims are subject to review to decide whether services are Covered, according to Plan limitations and exclusions. You must comply with requests for additional medical documentation, as deemed necessary by the Claims Administrator, to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all medical documents. Treatment decisions are independent from payment decisions.

The patient’s Physician is responsible for deciding whether treatment should be rendered despite whether the charges are totally or partially included in, or excluded from, Coverage under the Plan. If any of the entities used to determine the Medical Necessity or the investigative nature of a drug, device, supply, treatment or any other medical service, reverses, modifies, or establishes its policy for such expenses and makes such changes retroactive, the Plan will not make payment for such retroactive incurred expenses. The Plan will not seek refunds for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

Please refer to **Appendix C – Exclusions** for a list of Plan Exclusions.

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## SECTION VII - CLAIM SUBMISSION AND REVIEW PROCEDURES

### A. How to Obtain Benefits / Claim Submissions

**Prescription Drug Claims.** Refer to Section III - Covered Services under Prescription Drug Expenses for details on how to obtain benefits.

### B. Time Limit on Claim Submission

Claims should be submitted as incurred. However, to be considered for benefits, claims must be submitted (postmarked) to Medco within 12 months from the date the Covered Expenses were incurred. This time limit may be extended when this Plan is secondary and Medco receives the claim within 90 days after the date of the other plan's explanation or denial. This extension will not apply if the other Plan denies the claim for late submission based on their late filing time limit.

### C. Prescription Drug Claim Inquiries

When you have any questions concerning your Coverage, you may phone the SCSD Benefits Office at the following numbers: 315-435-4180 or 315-435-4532 or 315-435-4016 or phone Medco toll-free at 1-800-711-0917.

### D. Claim Appeals Procedure
**Medco Claims Administration.** If you disagree with any benefit determination or denial made by Medco, you may call or write to *Medco* within 30 days from the date of denial for further explanation. If you are not completely satisfied with Medco’s initial response, you may submit your concerns in writing with any additional information and follow the instructions below.

**For all claims other than member submitted paper claims (mail or retail):**

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal.

**For member submitted paper claims:**

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. You will receive an explanation of benefits within 30 days of receipt of your claim. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of the receipt of notice of the initial decision.

**Administrative Reviews and Appeals** are applied to the following types of pharmacy benefit components:

- Cost share (including co-payments and deductibles)
- Pharmacy network (participating or non-participating)
- Plan exclusions (for certain categories of drugs, such as cosmetic, fertility, etc.)
- Plan limitations (such as maximum days supply, maximum refill limits, etc.)

For initial administrative reviews, this information should be mailed to:

Medco of Irving
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Administrative Reviews
(800) 946-3979

**Clinical Reviews and Appeals** are applied to the following types of pharmacy benefit components:

- Coverage Programs (Prior Authorization)
- Incentive co-payments (formulary incentives, generic incentives)

For initial clinical reviews, this information should be mailed to:

Medco of Irving
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Coverage Appeals
(800) 864-1135

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If the first step appeal is denied, you may request a second level appeal in writing, within 60 days of the receipt of
notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to:

Syracuse City School District  
Employee Benefits Department  
725 Harrison Street  
Syracuse, NY 13210  
Attn: Prescription Program Appeals

Your appeal must be in writing and mailed to the appropriate address within 60 days from the date of the written denial. The plan reserves the right to maintain denial of benefits without further review for any appeals received more than 60 days after the initial notice of claim denial.

Your documentation will be handled in accordance with all HIPAA regulations. Your claim(s) will be reviewed by the Benefits Committee, to determine covered benefits within plan parameters.

SECTION VIII - FREQUENTLY ASKED QUESTIONS

How do I know if a drug is brand or generic?

Many drugs are available in generic form at significant savings. You may talk with your doctor about the substitution of generics when possible. Your retail pharmacy and mail order facility will always substitute generics when available unless the doctor specifies brand name only, dispense as written. If you are not sure if a medication is available in generic you are welcome to call Medco and a member service representative will assist you, or visit medco.com to see if a generic is available.

Can I choose the brand name drug if there is a generic available?

The choice is yours, however, your out of pocket expense will be greater. In accordance with state statute, SCSD has a mandatory generic program in place which means that you will pay the applicable brand copayment plus the difference in cost between the generic and brand drug cost. Generic drugs meet the same Federal Food and Drug Administration (FDA) standards for purity, safety, and strength as brand-name drugs. Choosing generic drugs whenever possible results in lower copayment for you and lower drug costs ultimately for your prescription drug program. However, when a physician includes ‘DAW” (meaning dispense as written) on your prescription, it will be filled as such.

How are drugs covered that are administered in a doctor’s office?

If the drug is covered in accordance with plan parameters, it may be covered under the Major Medical Benefit that falls under your Health program. Typically, a drug that is administered in a physician’s office would not be covered under the prescription drug program.

Does the Preferred Prescriptions Member Guide ever change?

If a drug is removed from the market for safety reasons, it will be removed from the preferred formulary. Otherwise, drugs may be removed from the preferred formulary up to two times per year. If a drug is removed from the preferred formulary, and it is not removed for safety reasons, it would still be available under the plan; however the drug would become a non-preferred drug. Drugs may be added to the preferred formulary listing up to four times per year,
meaning that these drugs would move to brand-preferred. Members or their dependents who take a drug that changes to non-preferred status or is removed from the preferred formulary due to safety reason, will be notified by Medco via mail. In addition, the Benefits Office will be notified. Additions and deletions to the preferred formulary are decided upon by an independent Pharmacy and Therapeutics (P&T) Committee, which consists of physicians and pharmacists dedicated to providing patients with high-quality, cost-effective drug therapy. The P&T Committee meets regularly to maintain an up-to-date and comprehensive formulary that follows current medical practices. Drugs are selected for addition to the preferred formulary after considering safety, efficacy, uniqueness and cost. See Section V – Formulary.

When would I use the Specialty Pharmacy?

For rare or chronic conditions, such as anemia, Hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis, the specialty pharmacy would be used. Nurses and pharmacists, who are trained in specialty pharmacy drugs and coordination of home care and other healthcare services as they relate to specialty drugs are able to assist. For more information, contact Medco’s Special Care Pharmacy (which is their specialty pharmacy) at 800-939-2108.
APPENDIX B

Definitions

Syracuse City School District
Health Benefits Plan

(A self-funded plan for Employees and Retirees of SCSD)
APPENDIX B – DEFINITIONS

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

**ACCIDENTAL INJURY** - Non-occupational bodily Injury caused by an event that is sudden and not foreseen, and is exact as to time and place.

**ACTIVELY EMPLOYED** - An Employee is Actively Employed who:

a. Performs for the employer, all the substantial and material duties of a job for personal income, profit, gain; or
b. Is scheduled to perform and performs regularly a minimum of 4 hours per day or 20 hours per week; or

c. Works on the business of the employer at a place of business other than a residence.

An Employee shall be deemed Actively Employed on each day of regular paid vacation, holidays authorized Leave of Absence or regular nonworking days. A terminated Employee, or an Employee on unauthorized Leave of Absence, lay off, or whose employment has been terminated is not considered Actively Employed.

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

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

**ALLOWABLE SERVICES OR SUPPLIES** - See Covered Services or Supplies.

**AMBULATORY SURGERY** - Surgery rendered on other than an Inpatient basis in a Doctor’s office, clinic, Ambulatory Surgical Facility or Outpatient department of a Hospital or other location.

**AMBULATORY SURGICAL FACILITY** - A specialized facility that meets fully all of the following tests:

1. It is established, equipped and operated according to the applicable laws of the jurisdiction in which it is located, primarily to do surgical procedures;
2. It is operated under the full-time supervision of a Doctor, permits a surgical procedure to be done only by a Doctor who, at the time of the operation, is privileged to do such procedure in at least one Hospital in the area, requires licensed anesthesiologist to administer anesthesia, (except local infiltration anesthetics).
3. It provides at least two operating rooms and at least one post anesthesia recovery room, is equipped to do diagnostic X-ray and laboratory examinations, has trained personnel and necessary equipment (including but not limited to a defibrillator, a tracheotomy set and a blood bank or other blood supply) to handle any foreseeable emergencies;
4. It provides the full-time services of one or more registered professional nurses for patient care in the operating rooms and post anesthesia recovery rooms; maintains a written agreement with at least one local Hospital for immediate patient acceptance for complications or postoperative confinement.
5. Maintains medical adequate records for each patient (to include an admitting diagnosis, medical history, operative report, anesthesia record and a discharge summary); provides an ongoing quality assurance program; and
6. It does not provide a place for patient to stay overnight.
**AMENDMENT OR AMENDED** - A change, revision, deletion or addition to the Plan by the Plan Administrator.

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

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

**BIRTH CENTER or BIRTHING CENTER** - A facility that meets fully all of the following tests:
1. It is established, equipped and operated according to the applicable laws of the jurisdiction in which located to primarily provide maternity care during labor, delivery and immediate postpartum period and all care of infants born at the center;
2. It charges for the services and supplies it provides and operates under the supervision of a medical Doctor (MD) specializing in obstetrics and gynecology. It has a medical Doctor or registered midwife present at all births and during the immediate postpartum period and provides full-time nursing services.
3. It provides at least two beds or birthing rooms for patients in labor and during delivery and is equipped, or has access through a contract with local medical facility, to do diagnostic X-ray and laboratory tests needed for the mother and newborn; is equipped with supplies to perform minor Surgery, and to administer local anesthetic. It provides equipment and trained personnel needed to handle medical emergencies and to provide immediate support measures to sustain life for complications arising during labor or for new born abnormalities that impair function and threaten life;
4. It maintains a written agreement with at least one local Hospital for immediate acceptance of patients who develop complications;
5. It has an admission policy of accepting only patients with low risk pregnancies; maintains written medical records for each patient admitted and each patient born at the center; and
6. It provides an ongoing quality assurance program by medical Doctors (MD), other than those who own or direct the facility; and extends staff privileges to Physicians who have obstetrical or gynecological care privileges at a local Hospital.

**BRAND NON-PREFERRED DRUGS** — These are typically newer or highly advertised drugs, which are also referred to as “Tier 3” drugs. Many of these drugs have a lower cost brand or generic available. These drugs are determined by the Plan’s Pharmacy and Therapeutics Committee as being duplicative or as having Preferred Drug alternatives available. Benefits are provided for Non-Preferred Drugs; however, copayments will be higher than for Preferred Drugs. See Formulary.

**BRAND PREFERRED DRUGS** — FDA approved drugs under patent to the original manufacturer and only available under the original manufacturer’s branded name. Brand-name drugs are generally given patent protection for 20 years from the date of submission of the patent, therefore a generic drug is not available. This provides protection for the innovator who laid out the initial costs (including research, development, and marketing expenses) to develop the new drug. They are referred to as “Tier 2” drugs and include the majority of brand name drugs available today. Brand-name drugs are patent-protected and product-trademarked. See Formulary.

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

**CALENDAR YEAR DEDUCTIBLE** - The amount of Allowable Fees that must be paid by the Enrollee each Calendar Year before the Claims Administrator can determine benefits. See also Deductible.

**CERTIFIED PSYCHIATRIC NURSE** - A licensed registered professional nurse who is certified by state regulatory
agency for Mental Health Care or, if not state regulated, must be certified by the American Nurses Credentialing Center as a clinical specialist in child/adolescent or adult Mental Health Care.

**CERTIFIED PSYCHIATRIC SOCIAL WORKER** - A licensed social worker with at least six years of post degree experience who has been certified by the New York State Board for Psychiatric Social Work or similar qualifications outside New York.

**COINSURANCE** - Coinsurance percentages represent the portions of covered expenses paid by the covered person. These percentages apply only to covered expenses which do not exceed the reasonable and customary charges. The covered person is responsible for all non-covered expenses and any amount which exceeds the reasonable and customary charge for covered expenses.

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

**CONTRIBUTION** - See Participation Contribution.

**CONVALESCENT CARE FACILITY** - See Skilled Nursing Facility.

**COPAYMENT** - That figure shown as a percentage used to compute the amount of benefits available or a dollar amount applied to Allowable Fees. The Covered Person is responsible for payment of the Copayment reduction amount.
1. Percentage Copayment is the percentage of Allowable Fees, after applicable Deductible, that the Plan pays for Covered Services and Supplies under Major Medical Expense Benefits. The Enrollee is responsible for payment of the balance.
2. Network Copayment is the portion of Network Allowable Fees that the Employee must pay to the Participating Provider. The balance is paid by the Plan.
3. Drug Copayment is the dollar amount that the Employee must pay toward the cost of a generic or brand name drug purchase. This Copayment is separate from any other Plan Copayments. The balance of Allowable Fees is paid by the Plan.

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

**COVERED EXPENSES** - See Allowable Fees.

**COVERED PERSON** - The Enrollee and any enrolled Eligible Dependents.

**COVERED PROVIDER** - See Provider

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

**CREDITABLE COVERAGE** – prescription drug coverage that is of equal or greater value than Medicare standard prescription drug coverage (Medicare Part D).

**CUSTODIAL CARE** - Any institutional, Outpatient or professional care which is not for diagnosis or treatment. Treatment is also Custodial Care when it is primarily to meet personal needs. Examples of Custodial Care are: assistance in the activities of daily living (such as help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine); administration of oral medications; assistance with supportive or Maintenance Care Physical Therapy; care due to incontinence; turning and/or positioning in bed; acting as a companion or sitter; or nurse aide services.
DEDUCTIBLE - The amount of Allowable Fees that must be paid by the Enrollee before certain benefits can be determined by the Plan Claims Administrator. See also Calendar Year Deductible.

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

DISPENSING LIMITS - For certain drugs, the plan normally provides coverage up to specified dispensing limits. These dispensing limits are established by physicians, including board certified and nationally respected physicians, clinical pharmacists and others. Pharmaceutical manufacturer and FDA guidelines are also used in determining dispensing limits. Physicians are usually acquainted with these procedures, and pharmacists normally check with physicians when the pharmacist has a reason to want to assure prescription accuracy, even if obtaining this assurance may delay immediate filling of a prescription.

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

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

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

ELIGIBLE DEPENDENTS - See Dependents.

ELIGIBILITY WAITING PERIOD - See Waiting Period.

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

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

ESTOPPEL - a bar or impediment which precludes allegation or denial of a certain fact or state of facts, in consequence of previous allegation or denial or conduct or admission, or in consequence of a final adjudication of the matter in a court of law (Black’s Law Dictionary, 5th ed.).

EXPERIMENTAL - See Investigational or Experimental.
FORMULARY – A list developed by an independent panel of physicians and pharmacists that contains preferred medications approved for coverage. The drugs on the list are chosen based on comparative clinical effectiveness, safety profiles and opportunities to help contain costs. This list is maintained by the Plan’s Pharmacy and Therapeutics Committee for use under the Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically and is therefore subject to change. If not otherwise excluded, the Formulary includes all Generic, Preferred and Non-Preferred Drugs.

FULL BENEFITS or FULL NETWORK BENEFITS - 100% of Allowable Fees after any applicable Copayment or Deductible.

FULL-TIME - A basis of employment that requires the Employee to be at work for at least the qualifying hours per week based on criteria established by SCSD or by negotiated agreement.

GENERAL HOSPITAL - See Hospital.

GENERIC DRUG - A drug available only upon the written prescription of a Physician, used for the treatment of an Illness or Injury. A generic drug is the chemical equivalent of a drug that has an expired patent. When a brand name drug's patent expires, other pharmaceutical companies can produce the same active chemical compound and sell the drug under its generic name. In the United States, the Food and Drug Administration (FDA) requires that all drugs, whether a brand name drug or a generic drug, meet standards of safety, strength, purity and effectiveness. A drug may be chemically exact but not bioequivalent. In other words, two different products of the same drug may not be absorbed into the body in exactly the same way. Bioequivalence depends on how the drug is formulated and how it is absorbed and eliminated by the body. Other ingredients can affect the absorption of the drug. These include starch fillers, gum-like substances and other products which allow a drug to be formulated into a pill or capsule. Factors such as a person's age, body mass, kidney, liver and intestinal function can also affect the absorption of the drug by the body. See Formulary.

HEALTH CARE BENEFITS - Hospital-medical-surgical benefits.

HEALTH CARE PROFESSIONAL - A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

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

HOME HEALTH CARE AGENCY - An agency that meets all of the following criteria:
1. It must be duly accredited to provide skilled services and other therapeutic services according to state regulations; and
2. In New York State, it must be certified and have a valid license under Article 36 of the New York State Public Health Law. If outside New York State, it must have an appropriate operating certificate issued by the appropriate state agency in the state where the care is rendered. The Provider outside New York State must be a Hospital or a nonprofit or public home health service or agency.
3. An agency that is a participating Home Health Care Agency in the POMCO Participating Provider Networks sponsored by the Plan.

HOME HEALTH CARE PLAN - A plan to provide out of Hospital care to a person rendered by an approved Home Health Care Agency. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he or she did not have the care and treatment stated in the care plan.
HOSPICE AGENCY - An organization that has an appropriate operating certificate issued by the New York State Department of Health to provide hospice care. Outside New York State, the hospice organization must be certified under criteria similar to those used in New York by a state agency in the state where the hospice care is provided; or it must be a Medicare approved Hospice Agency.

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

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

ILLNESS - Any Sickness or disease that manifests treatable symptoms and requires treatment.

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

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

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

INPATIENT OR INPATIENT CARE - The period during which you are treated at a Hospital or Skilled Nursing Facility or other facility as a registered bed patient.

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

INVESTIGATIONAL OR EXPERIMENTAL - Any care that is not widely accepted professionally in the United States as effective, appropriate and essential treatment of a reported Illness or Injury based upon recognized standards of health care. A drug, device, medical treatment or procedure is Experimental or Investigational if:
1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished or an FDA approved drug or device is used for purposes other than those conditions for which approved; or
2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to decide its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
3. Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;

4. Reliable evidence shows that the consensus among experts is that the drug, device or medical treatment or procedure once recognized as effective is no longer considered usual, customary, reasonable or necessary care;

5. The Centers for Medicare and Medicaid Services coverage criteria are not met for the drug, device or medical treatment or procedure;

6. The Plan Administrator, in its sole discretion, decides that the treatment, procedure, device, drug or medicine is Experimental or Investigational. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treatment facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure. If any of the entities used to determine the Investigational nature of a drug, device, supply, treatment or any other medical service, reverses, modifies, or establishes its policy or protocol for such expenses and makes such changes retroactive, the Plan will not make payment for retroactive incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

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

**MAIL SERVICE** - A pharmacy that dispenses long-term or maintenance prescriptions through the mail. This usually saves members money because in most cases they can purchase a 90-day supply for a lower copayment than if they were to purchase the same amount at a retail pharmacy.

**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.

**MAINTENANCE MEDICATIONS** - Maintenance medications are typically those taken on a regular or long-term basis. However, any prescription your doctor writes for more than a 30-day supply plus refills is considered a maintenance medication. Examples include medication for high blood pressure, heart conditions, arthritis, diabetes, and hormone replacement, as well as antidepressants.

**MEDICAL CARE BENEFITS** - Hospital-surgical-medical benefits.

**MEDICAL INTERVENTION** - Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

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

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

The Plan Administrator reserves the right to decide in its discretion, if a service or supply is Medically Necessary. The determination will consider but not be limited to, the findings and assessment of the following entities:
1. The Office of Medical Application of Research of the National Institutes of Health, the Office of Technology Assessment of the United States Congress, the Federal Centers for Medicare and Medicaid Services, or any similar entities;
2. The National Medical Associations, Societies and Organizations;
3. The FDA; or
4. The Plan Administrator's own medical and legal consultants and advisors.

The fact that a Physician or other health care professional may prescribe, recommend, order or approve a service or supply does not, by itself, decide Medical Necessity or make such service or supply eligible for benefits, even if not expressly excluded under the Plan. If any of the entities used to determine the Medical Necessity of a drug, device, supply, treatment or any other medical service, reverses, modifies, or establishes its policy or protocol for such expenses and makes such changes retroactive, the Plan will not make payment for retroactive incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

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

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

MENTAL HEALTH NURSE - See Certified Psychiatric Nurse.

MENTAL ILLNESS - See Mental Health Care.

MISCELLANEOUS HOSPITAL EXPENSES - Charges for necessary services and supplies for medical or surgical treatment billed by the Hospital, excluding professional fees.

NETWORK PROVIDER - See Participating Provider.

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

NON-PARTICIPATING PHARMACY — a pharmacy which does not participate in the Medco network of participating pharmacies.

NON-PARTICIPATING PROVIDER - (Out of Network) An organization, Physician, Hospital or other health care Provider that, at the time Covered Services or Supplies are provided, does not have a contract or agreement with the Participating Provider network selected by the Plan to provide medical care to the Covered Persons under the Plan.

OCCUPATIONAL THERAPY - Therapeutic use of work, self-care and play activities to increase independent function, enhance development, and prevent disability; may include adaptation of task or environment to achieve maximum independence and to enhance quality of life.
OUTPATIENT - Care rendered in the Outpatient or emergency department of a Hospital or other health facility or care rendered in the Provider's office, patient's home or other care rendered on other than confinement basis.

PARTICIPATING PHARMACY — a pharmacy which participates in the Medco network. These pharmacies have agreed to a contracted rate for covered prescriptions for members. To locate a participating pharmacy, members may go to www.medco.com or call Member Services at 1-800-711-0917.

PARTICIPATING PROVIDER - An organization, Physician, Hospital or other health care Provider that, at the time Covered Services or Supplies are provided, has a contract or agreement with the Participating Provider network selected by the Plan to provide medical care to the Covered Persons under the Plan.

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

PHYSICAL THERAPY - Rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet, and massage are used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living.

PHYSICIAN - A medical Doctor, podiatrist, osteopath and certified nurse midwife who is legally licensed and performing services within the scope and jurisdiction of such license. Definition also includes licensed clinical psychologists, Certified Psychiatric Nurse and Certified Psychiatric Social Worker for the treatment of Mental Illness, dentists for Covered health/dental services, and chiropractors for Covered chiropractic care.

PLAN OF CARE - See Approved Care.

PLAN ANNIVERSARY DATE - The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

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

PREFERRED PRESCRIPTIONS MEMBER GUIDE – This is a guide to medications within select therapeutic categories for prescription drug plan members. It is not a full formulary and purposely omits many categories. Within the categories represented, this drug list will help the physician and plan participants identify products for therapeutic purposes.

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

PRIOR AUTHORIZATION - Before certain medication or quantities of a medication above established dispensing quantities are dispensed, a member's physician may be required to obtain prior approval from Medco. If a prescription drug requiring prior authorization is not first approved for coverage under the plan, you will be responsible for paying the full cost of the medication.

PRIOR PLAN - The prior group medical plan offered by the Plan Sponsor.

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

PROVIDER - Any Doctor, dentist, registered professional nurse, certified nurse midwife, optometrist, physical therapist or occupational therapist, speech therapist, podiatrist, psychologist, Certified Psychiatric Social Worker, Certified Psychiatric Nurse, independent laboratory or other Covered facility/agency legally licensed and performing a Covered service within the scope of such license and in the state of such license.

PSYCHIATRIC CARE - See Mental Health Care.

PSYCHIATRIC FACILITY: A private facility (not government owned) that has been approved by the Joint Commission on Accreditation of Health Care Organizations as an Inpatient facility for the treatment of Mental Illness and is so licensed by appropriate state agencies.

PSYCHIATRIC NURSE - See Certified Psychiatric Nurse.

PSYCHIATRIC SOCIAL WORKER - See Certified Psychiatric Worker.

REHABILITATION FACILITY - See Skilled Nursing Facility.

REHABILITATIVE OR REHABILITATION - Medical treatment intended to restore (bring back) a person to a former or optimal (best possible) state of health following an Illness or Injury.

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

SELF-ADMINISTERED INJECTABLES — Self-administered injectable medications are defined as those drugs which are Medically Necessary, administered more often than once a month by patient or family member, administered subcutaneously or intramuscularly, deemed safe for self-administration as determined by the Plan’s Pharmacy and Therapeutics Committee, prior authorized by the Plan, and obtained form a participating Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered self-administered injectable drugs. Preferred Self-Administered Injectables are listed in the Plan's Prescription Drug Formulary.

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

SICKNESS - See Illness.

SKILLED NURSING FACILITY - An institution meeting at least one of the following requirements:
1. The facility must be accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Health Care Organizations; or
2. The facility must be a Skilled Nursing Facility, Convalescent Care Facility, Rehabilitation Facility or other Inpatient facility certified by Medicare to receive benefits under Part A, Skilled Nursing Facility Coverage.

SPECIAL CARE PHARMACY – Medco refers to its specialty pharmacy as a Special Care Pharmacy. Refer to Specialty Pharmacy definition below for more details.

SPECIALTY PHARMACY – Prescription drug medications, which provide treatments for patients with rare or chronic conditions, are obtained through specialty pharmacy. Some conditions, such as anemia, Hepatitis C, multiple
sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis, are treated with specialty medications. Medco’s specialty pharmacy is called its Special Care Pharmacy. If you use specialty medications, Medco’s Special Care Pharmacy may include the following: up to a 90 day supply with one copayment; access to nurses and pharmacists who are trained in specialty pharmacy; and coordination of home care and other healthcare services as they relate to specialty drugs. For more information, contact Medco’s Special Care Pharmacy at 800-939-2108. Using specialty pharmacy will typically result in lower costs than a retail setting.

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

SPELL OF ILLNESS - A period beginning with the first allowable care for treatment of any Illness or Injury as an Inpatient in a Hospital, Skilled Nursing Facility or Birthing Center 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 Birthing Center.

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

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

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

TOTAL DISABILITY - The following:
1. For the Employee: Being completely unable, as a result of Sickness or Injury, to do the substantial and material duties of such Employee's regular employment, or engage in a similar occupation for which the person is reasonably suited by reason of education, experience or training; or
2. For the Dependent: The inability, as a result of Sickness or Injury to engage in the normal activities of a person of like age and sex who is in good health.

USUAL, CUSTOMARY AND REASONABLE CHARGE (UCR) - The lowest of the actual charge for the service or supply; or the usual charge by the Doctor or other Provider for the same or similar service or supply; or the usual charge of other Doctors or other Providers in the same or similar geographic area for the same or similar service or supply (prevailing fee). In the determination of benefits for a claim, the usual level of charges may be modified by a relative value study, where appropriate, to model actual claims experience in a given area across a range of percentiles. The term "area" as it would apply to any particular service, medicine, or supply means a zip code, county or such greater area as is necessary to obtain a representative cross section of level charges. The part of the cost that exceeds that of any other services that would have been sufficient to safely and adequately diagnose or treat an individual's physical or mental condition will not be deemed as usual, customary or reasonable charges. The Claims Administrator makes the determination of the Usual, Customary and Reasonable (UCR) Charge for a service or supply.

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

Plan Exclusions

Syracuse City School District
Health Benefits Plan

(A self-funded plan for Employees and Retirees of SCSD)
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 services, 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.

In addition to limitations and exclusions shown elsewhere in this document, charges for the following expenses will not be paid by the Plan, unless specifically shown otherwise for Plan Coverage. Also, please refer to Appendix B – Definitions.

1. **Plan Coverage not in Effect**. Services, supplies and/or prescription drugs incurred while an individual is not eligible and enrolled in the Plan or incurred before the Plan became effective or after the Plan is canceled. Services or supplies that are not Covered according to Plan limitations and exclusions in effect at the time expenses were incurred.

2. **Unreasonable Charges**. Charges that are more than any fees found Usual, Customary, and Reasonable (UCR) according to Plan provisions.

3. **Not Physician Approved/Not under Care of Physician**. Services, supplies and/or prescription drugs not recommended or approved by a Physician or dentist, or received while not under the care and treatment of the ordering Physician or dentist, or services not rendered by a Covered Provider.

4. **Not Medically Necessary**. Services, supplies and/or prescription drugs that are not Medically Necessary according to Plan provisions for the treatment of an Illness or injury. Preventive care or well care such as routine physicals, screening exams, premarital exams, school exams, camp or sport exams, and related services are not Covered. Tests unrelated to symptoms or treatment of Illness or injury, inoculations, immunizations, vaccinations, or other preventive shots are not Covered. Exception: Care specifically included under Preventive Care Expense Benefits, or voluntary sterilization expenses.

5. **Blood Donations**. Services, supplies and/or prescription drugs for autologous or direct blood donations and storage when done as precautionary measure in case the need for blood arises. Exception: Autologous or direct donation services and supplies preceding Surgery that could require blood transfusion as specifically included in the Plan.

6. **Experimental or Investigational/Acupuncture/Alternative Care**. Services, supplies and/or prescription drugs related to care considered Experimental or Investigational, according to Plan provisions, at the time expenses are incurred. Refer to Appendix B - Definitions under Investigational or Experimental. Transplants will be considered investigative, except those that are specifically covered by and meet the Federal Centers for Medicare and Medicaid Services coverage criteria in effect at the time expenses are incurred. Services or supplies connected with care such as acupuncture, holistic medicine, hypnotherapy, environmental ecology, and other alternate type medicines are not Covered.

7. **Drugs/Infertility/Birth Control/Vitamins/Supplements**. Services, supplies and/or prescription drugs that can be purchased without a Physician's prescription, contraceptive (birth control) drugs and devices, infertility drugs, or most
vitamins and supplements, including nutritional supplements or food products, whether or not obtainable by prescription. Exceptions: Insulin, pre-natal vitamins and certain other prescribed vitamins, and birth control drugs when found Medically Necessary for the treatment of specific organic disease and approved as a Covered benefit under the separate SCSD Pharmacy Benefit Manager Prescription Drug Expense Benefit program (Appendix A).

8. Home Medical Supplies. Services, supplies and/or prescription drugs for home use that are not directly supplied by professional home care services, or that is not for the operation of Covered Durable Medical Equipment. Items primarily intended for comfort or to support activities of daily living, such as diapers, ice bags, incontinent pants, support stockings, nutritional supplements, cervical or lumbar pillows. Exception: Covered colostomy supplies, catheters and related supplies, Covered syringes and needles for conditions such as insulin dependent diabetes, or certain supplies for diabetics specifically included as Covered Expenses.

9. Personal Items. Personal comfort items such as telephone, radio, television or barber services charged by any facility or other Provider.

10. Durable Medical Equipment/Braces/Prosthetics/Devices. Services, supplies and/or prescription drugs related to duplicate medical equipment, braces, Prosthetics or other devices; or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction. The purchase of Durable Medical Equipment that can be rented unless the length of time the equipment will be needed makes the purchase of such equipment less costly than the rental. The purchase or replacement of any biomechanical prosthetic device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, orthotics or splints used primarily for athletic use.

11. Vision. Services, supplies and/or prescription drugs related to vision therapy, visual aids, eyeglasses or contact lenses, or their repairs, and related examinations to decide the need for, adjustments or repair of them. Surgical treatment for the correction of a refraction error, including radial keratotomy when corrective lens may be worn. Exception: Services specifically included in the Plan such as initial contacts following cataract or other intraocular Surgery, lenses for aphakia and soft lenses or scleral shells intended for treatment of disease or Injury. Vision care benefits excluded under this Plan may be covered under your Vision Care Plan.

12. Hearing. Services, supplies and/or prescription drugs related to hearing aids, tinnitus masking devices, (or similar devices), communication devices, and related examinations to decide the need for, adjustments or repair of them.

13. Dental Care. Services, supplies and/or prescription drugs related to care or treatment of the teeth, gums or alveolar process (dental work), such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered dental in nature. Adjustments, services and supplies related to appliances for treatment of temporomandibular joint disorders (TMJ) or similar disorders. Exception: Charges by a dentist or 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, treatment and Surgery for joint disorders, freeing of muscle attachments, or for care rendered for Accidental Injury to sound natural teeth within 12 months after the date of accident. Dental care benefits excluded under this Plan may be covered under your Dental Care Plan.

14. Anesthesia. Services, supplies and/or prescription drugs for the administration of anesthesia for any Surgery or treatment not Covered by the Plan.

15. Midwife/Doctor Duplicate Services. Services, supplies and/or prescription drugs that are duplicative because they are provided by both a nurse midwife and Doctor.

17. Educational/Cognitive/Therapy for Developmental/Birth Defects. Services, supplies and/or prescription drugs 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 development for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spina bifida, birth defects, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest Mental Illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

18. Occupational Therapy. Services, supplies and/or prescription drugs related to Occupational Therapy unless part of an approved Physical Therapy treatment plan to restore bodily function lost due to disease or injury or loss of body part or when part of an Approved Plan of Care for services by a Home Health Care Agency, Hospice Agency, or Inpatient services by a Hospital or Skilled Nursing Facility.

19. Foot Care/Shoes/Orthotics/Supports. Services, supplies and/or prescription drugs related to routine foot care such as cutting or removal of corns, calluses, nails, routine hygienic care, or preventive Maintenance Care (ordinarily within the realm of self care). Orthopedic shoes, foot orthotics or other supportive foot devices and treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions or subluxations of the feet despite underlying pathology. Exceptions: Routine foot care ordered by an attending medical Doctor while treating a person with an insulin dependent diabetic condition, removal of nail roots and open cutting corrective procedures.

20. Weight Reduction/Diet Management/Exercise. Services, supplies and/or prescription drugs related to weight reduction or diet management for treatment of obesity. Diet management, exercise programs or general conditioning programs even when ordered by a Physician. Exceptions: Limited Coverage for Physician medical management services (doctor’s office visits and laboratory testing) for certain conditions that meet Medical Necessity.

21. Inpatient Non-Acute Care/Custodial/Maintenance/Long Term Care. Services, supplies and/or prescription drugs related to any part of an Inpatient stay that is primarily for physical checkups, diagnostic testing, Custodial, Maintenance or long term care, residential, sanitarium type, rest cures, or for environmental change or care that cannot reasonably be expected to lessen the patient's disability enabling him or her to leave an institution. Exception: Hospice care services specifically included in the Plan.

22. Non-Acute Facilities. Services, supplies and/or prescription drugs rendered in a place of rest, a place for the aged, a nursing home or in an education facility, a place mainly for care of alcoholism, drug addiction, mental disorders or tuberculosis unless the facility and care rendered meets Plan requirements for Skilled Nursing Facility Coverage, or Alcohol/Substance abuse facility Coverage and private Psychiatric Facility Coverage for Inpatient Mental Illness care.

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

24. Custodial or Maintenance Care. Services, supplies and/or prescription drugs related to care found Custodial or Maintenance Care according to Plan provisions.

25. Reversal Sterilization Procedures. Services, supplies and/or prescription drugs related to the reversal of sterilization procedures, whatever the reason.

26. Birth Control. Services, supplies and/or prescription drugs related to or used for family planning, contraception.
counseling, or birth control, etc., whatever the reason. Exception: Voluntary sterilization specifically included for Plan Coverage.

27. Infertility/In-vitro/Artificial Insemination. Services, supplies and/or prescription drugs relating to artificial insemination, in vitro fertilization procedures or other artificial conception procedures. Services or supplies relating to treatment of infertility. However, Plan allows coverage for surgical or medical treatment to correct an identifiable diagnosed organic medical condition (other than menopause, climacteric changes or previous sterilization procedures). Documentation of the organic condition must be presented and the Claims Administrator must approve the Plan of Care for Coverage.

28. Surrogate Pregnancy. Services, supplies and/or prescription drugs related to surrogate maternity care, including but not limited to, those needed to start the Pregnancy, prenatal care, delivery or other procedure, and postnatal care. Benefits are available for newborns who are enrolled according to Plan requirements for newborn Dependent children.

29. Cosmetic/Elective Care. Services, supplies and/or prescription drugs connected with elective care, or cosmetic or beautifying Surgery. Reversal of elective, cosmetic or beautifying Surgery will not be Covered unless found Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Injury or Sickness or for reconstructive Surgery that is incidental to or follows Surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive Surgery because of a congenital disease or anomaly of a Dependent child that has resulted in a functional defect.

30. Hair Loss/Baldness. Services, supplies and/or prescription drugs related to hair loss or baldness including, but not limited to, human, or artificial hair transplants, other professional care to stimulate hair growth, drugs to eliminate baldness or stimulate hair growth, wigs and artificial hairpieces. Exception: Limited Coverage specifically included in the Plan for one hairpiece per lifetime for hair loss resulting from chemotherapy.

31. Smoking Cessation/Tobacco. Services, supplies and/or prescription drugs related to therapy for cessation of smoking or other use of tobacco products whether or not recommended, ordered, or prescribed by a Physician. Note: the SCSD Employee Assistance Program offers limited Coverage for smoking cessation. Contact the school district’s EAP coordinator for details.

32. Gender Identity Disorders. Services, supplies and/or prescription drugs connected to sex change Surgery or to any treatment of gender identity disorders.

33. Transportation/Travel. Services, supplies and/or prescription drugs related to transportation or travel by any means other than an ambulance even if ordered, recommended, or prescribed by a Physician. Services and supplies related to non-emergency ambulance services. Ambulance services when the patient could have been safely transported by other means of transportation.

34. Care by Relative/Household Member. Services rendered by an Immediate Relative or Household Member. Refer to Appendix B - Definitions under Immediate Relative and under Household Member.

35. Facility Employees. Separate charges for services by members of the staff employed by a Hospital, Skilled Nursing Facility, Convalescent Facility, Rehabilitation Facility, or by any Inpatient facility where care is received.

36. Free Care. Services, supplies and/or prescription drugs received for which no charge would have been made without Coverage under the Plan or for which there is no legal obligation for payment by the Enrollee or Dependent. Exception: Coverage to the extent federal and state law requires the Plan to allow benefits that would have been otherwise payable.

37. Condition Due to Military Service. Services, supplies and/or prescription drugs 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.

38. Illegal Care. Services, supplies and/or prescription drugs considered illegal according to any governmental laws or regulations.

39. Act of War/Riots. Services, supplies and/or prescription drugs received because of an Injury or Sickness due to participation in an act of war, whether declared or undeclared, or a warlike action in time of peace, or due to participation in a civil insurrection or riot. **Exception:** This exclusion does not apply if evidence can be shown that the Covered Person’s Injuries were the result of his/her medical condition (physical or mental) or from domestic violence. In this case, Plan coverage will be provided for expenses otherwise covered.

40. Work-Related/Occupational Conditions. Services, supplies and/or prescription drugs received because of an occupational Injury or an occupational Sickness that entitles the Covered Person to benefits under a worker's compensation, occupational disease law, or similar legislation. Payment will not be made even if you or your Dependent does not claim the entitled benefits.

41. Self-Inflicted Actions. Services, supplies and/or prescription drugs required due to an Illness or Injury resulting from self-inflicted actions of the patient whether or not based on rational judgment. **Exception:** This exclusion does not apply if evidence can be shown that the Covered Person’s Injuries were the result of his/her medical condition (physical or mental) or from domestic violence. In this case, Plan coverage will be provided for expenses otherwise covered.

42. Illegal Act/Driving Under the Influence/Assault. Services, supplies and/or prescription drugs required due to an Illness or Injury resulting from commission of or attempted commission of an illegal act that resulted in legal conviction. This includes, but is not limited to convictions for illegal occupation, felony acts, and driving under the influence of alcohol or drugs. Services or supplies required due to an Injury or Illness resulting from the commission or attempted commission of an assault. If a Covered Person is convicted for the illegal act, assault, DUI or DWI, then such convictions will serve as proof that the Covered Person committed the illegal act, assault, DUI or DWI. If not convicted, the Covered Person could be deemed to have committed or attempted to commit the illegal act or assault or to have been DUI or DWI based on the facts and circumstance involved, even if the person is not prosecuted or if prosecuted found not guilty of such acts. **Exception:** This exclusion does not apply if evidence can be shown that the Covered Person’s Injuries were the result of his/her medical condition (physical or mental) or from domestic violence. In this case, Plan coverage will be provided for expenses otherwise covered.

43. Government Programs. Services, supplies and/or prescription drugs that could be provided by or paid for by any governmental (domestic or foreign) program (other than Medicaid) under which you or your Dependent are or could be Covered. **Exception:** Coverage to the extent that such program requires the Plan to allow benefits that would have been otherwise payable. Medicare as specifically included in **Section V - Medicare Integration with Plan Benefits contained in the Health Benefits Summary Plan Description.**

44. Government Facilities/Institutions. Services, supplies and/or prescription drugs 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.

Syracuse City School District Health Benefit Plan Appendix C 07/01/06
c. State or local government-owned mental health facility that otherwise meets Plan limitations for mental health care.

d. Government-owned facility that otherwise meets Plan limitations for Coverage as an Outpatient Alcohol or Substance Abuse 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.

45. No-Fault Auto Insurance. Services, supplies and/or prescription drugs to the extent they are covered under a mandatory motor vehicle liability law that requires benefits be provided for personal Injury without regard to fault. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the automobile insurance denies its benefits (for services otherwise covered) due to driving under the influence (DUI) of alcohol or drugs, not Medically Necessary, or for late filing. However, service or supply fees, not paid under the no-fault insurance due to its deductible and maximum benefit limitations, will be Covered to the extent Allowable Fees would otherwise have been payable under this Plan.

46. Third Party Claim Settlement/Action. Services, supplies and/or prescription drugs for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or action). Exception: Conditional payments shown in Section IX - Other Provisions and Procedures under Right of Subrogation. Failure to comply with the conditions of the Plan's right to subrogation could result in denial of benefits.

47. Forms/Missed Appointments/Phone Calls/No Care Given. Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, or for services or supplies not actually received or provided.

48. Other Plan/Benefit Penalties/Primary Care Network/HMO Network. Services, supplies and/or prescription drugs to the extent such expenses were disallowed by a primary health plan due to failure by their enrollee or participant to follow the requirements of its managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to obtain services through a health maintenance organization (or similar organization including Medicare sponsored managed care organization); or failure to abide by the HMO primary Physician network.

49. Plan Penalties/Deductibles/Copayments/Benefit Limits. Services, supplies and/or prescription drugs to the extent they are not reimbursed due to benefit penalties, Deductibles, Copayments or other benefit limits under any portion of this Plan. Exception: When this Plan pays as secondary payer to another Plan according to the coordination of benefits provision.

50. Late Claim Filing. Services, supplies and/or prescription drugs for which an adequate claim is not filed with the Claims Administrator within the Plan time limit for claim submissions.

a. For a health benefits claim, the claim must be submitted (postmarked) no later than 90 days after the end of the calendar year in which the Covered Expenses were incurred unless the time limit was extended based on the date of a primary health plan explanation of benefits or denial.

b. For a prescription drug claim, the claim must be submitted (postmarked) no later than 12 months from the date from which the Covered Expenses were incurred unless the time limit was extended based on the date of a primary prescription drug plan explanation of benefits or denial.
51. **Not Included.** Services, supplies and/or prescription drugs 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 Coverage under the Plan even if Medically Necessary. This applies even if such services, supplies or Providers are not specifically excluded according to Plan provisions.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan:

Amendment Number: R 2006 - 001
Amendment Effective Date: January 1, 2008
Nature of Amendment: To add coverage for same-sex domestic partners of active employees

Section II – Eligibility and Enrollment, A. Eligibility for Plan Enrollment, paragraph 3. is amended to read:

3. **Dependents.**

   **c. Child Definition -**

   2) Any stepchild of the Employee or retiree **(or child of an Active Employee’s domestic partner)** who permanently resides in the Employee or retiree’s home.

   3) Any other child supported by the Employee or retiree, or the Spouse of the Employee or retiree, **or child of an Active Employee’s domestic partner** and permanently residing in the Employee or retiree’s home, provided the support and residence commenced before the child reached age 19; or

Paragraph 3. is further amended to add **d.** to read:

   **d. Domestic Partners of Active Employees,** according to the following criteria established by the Board of Education:

   1) The Active Employee and same-sex domestic partner individuals have an exclusive mutual commitment, similar to that of marriage, as evidenced by a Declaration of Domestic Partnership;

   2) The individuals are each other’s sole domestic partner and intend to remain so indefinitely;

   3) Neither partner is legally married to another person, and the Employee nor domestic partners cannot be legally married to each other in New York State;

   4) Neither individual is related by blood to a degree of closeness which would otherwise prohibit legal marriage in New York State;

   5) The Employee and domestic partner are at least eighteen (18) years of age and are legally competent to contract;

   6) The Employee and domestic partner are currently residing together and have resided together in a common household for at least eighteen (18) consecutive months and intend to reside together indefinitely;
7) Either (1) the individuals have never previously been in the status of domestic partner in any jurisdiction, or (2) at least eighteen (18) months have elapsed since the termination of a Declaration of Domestic Partnership, Affidavit of Domestic Partnership, or its equivalent in any jurisdiction (unless the reason for termination was the death of the other partner);

8) The Employee and domestic partner share joint responsibility for their common welfare and financial obligations demonstrated by the existence of a domestic partner agreement and at least three (3) other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable power of attorney or health care proxy, co-parenting agreement, or an adoption agreement.

9) The Employee must notify SCSD Benefits Department in writing through a Statement of Termination of Domestic Partnership within thirty (30) days. The benefit coverage for the former domestic partner will terminate immediately upon notification. A domestic partner is not a Qualified Beneficiary under COBRA.

The SCSD Benefits Office can answer questions concerning coverage for domestic partners.

Appendix B – Definitions, Dependent is amended to read:

**DEPENDENT** - An Enrollee's legal Spouse, an Active Employee’s domestic partner, or child who meets the conditions shown in Section II - Eligibility and Enrollment.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 002  
**Amendment Effective Date:** January 1, 2008  
**Nature of Amendment:** To extend benefits for occupational therapy in all settings.

Section IV - Covered Services, subsection E. Major Medical Benefits is amended to add paragraph 18 to read:

18. Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Appendix C - Plan Exclusions is amended to remove the exclusion for occupational therapy as shown below:

18. **Occupational Therapy.** Services, supplies and/or prescription drugs related to Occupational Therapy unless part of an approved Physical Therapy treatment plan to restore bodily function lost due to disease or injury or loss of body part or when part of an Approved Plan of Care for services by a Home Health Care Agency, Hospice Agency, or Inpatient services by a Hospital or Skilled Nursing Facility.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 003  
**Amendment Effective Date:** April 1, 2008  
**Nature of Amendment:** To add an inpatient hospital copayment of $100.00 for bargaining units 1, 2, 5 only (1- Teachers & Ancillary Services; 2- Administrators & Ancillary Services, and 5 - Maintenance & Trades).

Section I – Summary of Benefits, subsection C. Hospital Expense Benefits is amended to read:

<table>
<thead>
<tr>
<th>Sectio n</th>
<th>HEB Covered Services</th>
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</thead>
<tbody>
<tr>
<td>IV C</td>
<td>Hospitals, Other Facilities and Agencies</td>
<td>Most Inpatient admissions and home health care require a mandatory phone call to the Claims Administrator. See Section III - Benefits Management Program for details.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits are provided for services and supplies rendered and billed by a Covered Hospital, facility or agency for the treatment of an Illness or Injury. Inpatient private room will be allowed at the Average Semi-Private Rates, unless shown otherwise. Private duty nursing and Physicians charges are Covered separately.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospital Inpatient Copayment may apply.</strong> Benefit limits are per Covered Person and are cumulative for In Network and Out of Network Providers. Note: If you use an out of Network Provider you could be responsible for payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance.</td>
<td></td>
</tr>
</tbody>
</table>
| IV C 1 a | Acute Care General Hospital                       | **Bargaining units 1, 2, and 5 only:** $100.00 copayment per admission  
| Inpatient | Medical/Surgical, Maternity                       | Full Benefits for 365 benefit days per Spell of Illness.  
|          |                                                   | All other groups: Full Benefits for 365 benefit days per Spell of Illness.  
|          |                                                   | Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. Date of discharge is not allowable. Additional Coverage is available under Major Medical Expense Benefits.  
|          | Mental Illness Inpatient Limits                   | **Bargaining units 1, 2, and 5 only:** $100.00 copayment per admission  
|          |                                                    | Full Benefits up to 120 benefit days per Calendar Year when approved through the Benefits Management Program.  
<p>|          |                                                    | All other groups: Full Benefits up to 120 benefit days per Calendar Year when approved through the Benefits Management Program. |</p>
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<td>Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. In no event will the Plan pay more than 120 days per Calendar Year for any combination of Inpatient stays in an Acute Care General Hospital or Psychiatric Facility. Additional Coverage is not available under Major Medical Expense Benefits.</td>
</tr>
</tbody>
</table>
| IV C 8  | Alcohol/Substance Abuse Facility | Certified Acute Care General Hospitals only:  
  - Bargaining units 1, 2, and 5 only: $100.00 copayment per admission  
    - Full Benefits.  
  - All other groups:  
    - Full Benefits.  
  Other certified Substance Abuse Facilities:  
    - Full Benefits.  
  Limited to 30 days per confinement, per Calendar Year and 60 days per lifetime for each Covered Person. Services and Plan of Care must be approved through the Managed Care Program. Semi-private room limit. Additional benefits are not available under Major Medical Expense Benefits. |

Section IV – Covered Services, subsection C. Hospital Expense Benefits, paragraph 1. Acute Care General Hospital, a. Inpatient Services is amended to read:

1. Acute Care General Hospital

   a. Inpatient Services. **Copayments could apply to admissions to Acute Care General Hospitals; refer to Section I - Summary of Plan Benefits for details.**

Section IV – Covered Services, subsection C. Hospital Expense Benefits, paragraph is further amended to revise paragraph 8. Alcohol/Substance Abuse Facility to read:

8. Alcohol/Substance Abuse Facility.

   a. Inpatient

   Phone calls are required by you before Inpatient admissions. Refer to Section III - Benefit Management Program for instructions.

Benefits are available for Inpatient diagnosis and treatment of alcohol and or substance abuse rendered and billed by a certified Alcohol/Substance Abuse Facility when preapproved through the Benefit Management Program. Benefits will not be paid if services are obtained without such preapproval. Benefits will not be paid if the Claims Administrator does not approve Coverage for any portion of an Inpatient stay. Coverage for preapproved Inpatient days will be limited to a maximum of 30 days per Calendar Year and
60 days per lifetime for each Covered Person. Days do not count toward the General Hospital per Spell of Illness maximum. If a private room used, charges more than the Average Semi-Private Rate will be excluded. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training.

**Copayments could apply to admissions to Acute Care General Hospitals for alcohol and/or substance abuse treatment; refer to Section I - Summary of Plan Benefits for details.**

Refer to **Section I - Summary of Benefits** for benefit limits. Additional Coverage is not available under Major Medical Expense Benefits. Separate charges for staff Physicians, nurses or other employees are not Covered.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 004  
**Amendment Effective Date:** June 1, 2008  
**Nature of Amendment:** Mandatory mail order pharmacy for specialty medications

Appendix A, Prescription Drug Program, Section VIII – Frequently Asked Questions is amended to read:

**When would I use the Specialty Pharmacy?**

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling. These medications treat complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis.

As part of your prescription drug benefit, Syracuse City School District has arranged for you to have access to the enhanced services of Accredo Health Group, Medco’s specialty pharmacy, for your specialty medication needs. Accredo is a mail-order pharmacy dedicated to providing specialty medications.

The Syracuse City School District prescription drug program requires that certain specialty medications be accessed through Accredo for rare or chronic conditions.

If you are currently using a retail pharmacy to obtain your specialty medications, you may be required to transfer those prescriptions to Accredo. If you continue to purchase your medications from a pharmacy other than Accredo, you will be responsible for their full cost similar to the non-participating retail pharmacy procedures currently in your plan.

If you use specialty medications, Accredo’s extra services include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week  
- Personalized counseling from our dedicated team of registered nurses and pharmacists  
- Expedited, scheduled delivery of your medications at no extra charge  
- Refill reminder calls  
- Free supplies to administer your medication, such as needles and syringes

For more information about specialty medications and services or to confirm whether a medication you take is part of the specialty program, call the number on the back of your prescription drug ID card or visit www.accredohealthgroup.com.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 005  
**Amendment Effective Date:** August 1, 2008  
**Nature of Amendment:** To add an inpatient hospital copayment of $100.00 for bargaining units 6, 7, 8, 9, 10, and 12 (6 - Operations Plant, 7 - School Lunch, 8 - Aides and Assistants, 9 - Office Personnel, 10 - Health, and 12 - Native North Americans)

Section I – Summary of Benefits, subsection C. Hospital Expense Benefits is amended to read:

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<td><strong>Benefits are provided for services and supplies rendered and billed by a Covered Hospital, facility or agency for the treatment of an Illness or Injury. Inpatient private room will be allowed at the Average Semi-Private Rates, unless shown otherwise. Private duty nursing and Physicians charges are Covered separately.</strong></td>
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<td><strong>Hospital Inpatient Copayment may apply.</strong> Benefit limits are per Covered Person and are cumulative for In Network and Out of Network Providers. Note: If you use an out of Network Provider you could be responsible for payment of charges that are more than the Usual, Customary and Reasonable (UCR) allowance.</td>
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</tr>
</tbody>
</table>
| IV C 1a | Acute Care General Hospital | - **Bargaining units 1, 2, 5, 6, 7, 8, 9, 10, and 12 only: $100.00 copayment per admission**  
- Full Benefits for 365 benefit days per Spell of Illness.  
- All other groups: Full Benefits for 365 benefit days per Spell of Illness. |
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<td>Mental Illness Inpatient Limits</td>
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<td><img src="https://example.com" alt="Mental Illness Inpatient Limits" /></td>
</tr>
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<td>Alcohol/Substance Abuse Facility</td>
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<td>Inpatient</td>
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</tr>
<tr>
<td>IV C 8</td>
<td>Certifying Acute Care General Hospitals only:</td>
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<td><img src="https://example.com" alt="Mental Illness Inpatient Limits" /></td>
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</tbody>
</table>
Syracuse City School District Health Benefits Plan
Restated MPD of July 2006
Plan Amendment

The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

Amendment Number: R 2006 - 006
Amendment Effective Date: February 1, 2009
Nature of Amendment: To add an inpatient hospital copayment of $100.00 for bargaining unit 11 (11–Non-Certified Supervisors)

Section I – Summary of Benefits, subsection C. Hospital Expense Benefits is amended to read:

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</tr>
<tr>
<td>IV C 1a</td>
<td>Acute Care General Hospital Inpatient Medical/Surgical, Maternity</td>
<td>• <strong>Bargaining units 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12 only:</strong> $100.00 copayment per admission Full Benefits for 365 benefit days per Spell of Illness. • All other groups: Full Benefits for 365 benefit days per Spell of Illness. Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. Date of discharge is not allowable. Additional Coverage is available under Major Medical Expense Benefits.</td>
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</table>
|         | **Mental Illness Inpatient Limits** | • **Bargaining units** 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12 only: **$100.00 copayment per admission**  
Full Benefits up to 120 benefit days per Calendar Year when approved through the Benefits Management Program.  
• All other groups:  
Full Benefits up to 120 benefit days per Calendar Year when approved through the Benefits Management Program.  
Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. In no event will the Plan pay more than 120 days per Calendar Year for any combination of Inpatient stays in an Acute Care General Hospital or Psychiatric Facility. Additional Coverage is not available under Major Medical Expense Benefits. |
| IV C 8  | **Alcohol/Substance Abuse Facility**  
--- **Inpatient** | Certified Acute Care General Hospitals only:  
• **Bargaining units** 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12 only: **$100.00 copayment per admission**  
Full Benefits.  
• All other groups:  
Full Benefits.  
Other certified Substance Abuse Facilities:  
• Full Benefits.  
Limited to 30 days per confinement, per Calendar Year and 60 days per lifetime for each Covered Person. Services and Plan of Care must be approved through the Managed Care Program. Semi-private room limit. Additional benefits are not available under Major Medical Expense Benefits. |
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 007  
**Amendment Effective Date:** April 1, 2009  
**Nature of Amendment:** To add new special enrollment rights under CHIPRA

Section II Eligibility and Enrollment, subsection C. Effective Dates of Coverage, Special Enrollment Effective Dates is amended to add new special enrollment rights as paragraph (c) to read:

(c) New Special Enrollment Rights are effective April 1, 2009 under the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

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

1) 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

2) 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.
Syracuse City School District Health Benefits Plan
Restated MPD of July 2006
Plan Amendment

The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

Amendment Number: R 2006 - 008
Amendment Effective Date: January 1, 2010
Nature of Amendment: To incorporate Michelle’s Law under dependent eligibility

Section II Eligibility and Enrollment, subsection A. Eligibility for Plan Enrollment, paragraph 3. b. Dependents, Unmarried Children, is amended to read:

b. Unmarried Children of the Employee or retiree who are:

2) Over 19 years of age but under 25 who receive more than half of their support from the Employee or retiree and who are enrolled as full-time students and attending an accredited secondary College or University; school or institution of learning. Full-time status is defined by the College, University, school or institution; graduate-level students on internships are considered to be full-time students if the institution validates full-time status. 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.

Your unmarried Dependent child, between the ages of 19 and 25, for purposes of eligibility, shall be considered to still be a student for a period of 120 days prior or subsequent to graduation from, entrance to or enrollment/re-enrollment in high school or a College or University providing the student meets all other eligibility requirements.

Your Unmarried Dependent child, between the ages of 19 and 25 who is a full-time student becomes unable to attend school due to a disability that starts after age 19 could maintain student eligibility. To be eligible for this extension, medical certification must be submitted to the SCSD Benefits Office. This certification must show the child to be incapable of self-support by reason of permanent or long-term mental or physical disability that started after age 19. The eligibility should be established as early as possible following the start of the disability. If approved, the Dependent will continue to be eligible for student Coverage until the date the disability ends or until age 25 (limiting age for student eligibility), whichever occurs first. If the disability ends and the child returns to full-time student status before age 25, the Dependent's student eligibility will be extended beyond his or her 25th birthday for the exact length of the former disability.

Effective January 1, 2010, 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.

Your unmarried Dependent child between the ages of 19 and 25 who previously was not eligible for benefits or had benefits terminated and who returns to a full-time student status, 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, providing the student meets all other eligibility requirements.

Please Note
Eligibility for child attending school as a full time student will terminate at 12:01 a.m. on the date of his/her 25th birthday or the date at the end of student extension after disability. When eligibility ends, the child could qualify for Continuation of Coverage under COBRA shown later in this section.
Syracuse City School District Health Benefits Plan
Restated MPD of July 2006
Plan Amendment

The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

Amendment Number: R 2006 - 009
Amendment Effective Date: January 1, 2011
Nature of Amendment: To 1) incorporate the provisions of the federal Affordable Care Act and 2) clarify Plan coverage for certain healthcare facility employees.

The Introduction is amended to add:

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.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 315-435-4999.

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Section II Eligibility and Enrollment, subsection A. Eligibility for Plan Enrollment, paragraphs 3. b. and c. are amended to read:

3. Dependents.

The SCSD Benefits Office may require documentation of the Dependent status. If criteria of support is required, it will be deemed to have been met if the Employee or retiree contributes at least 50 percent to the support of the Dependent and that Dependent qualifies as an exemption on a current Federal income tax return filed by the Employee or retiree.

The following Dependents are eligible to be enrolled under an Employee or retiree’s family Coverage:

b. Children of the Employee or retiree who are:
1) The Employee’s or retiree’s biological child, stepchild, legally adopted child (or child placed for adoption or a pre-adoptive newborn), or a foster child who is under the limiting age of 26 years, regardless of marital status, financial dependence, residence, or student status. Your newborn child is eligible from the date of birth if enrolled in family Coverage within 30 days after the date of birth.

The dependent child cannot be covered under or be eligible for any other employer-sponsored group plan or policy; this restriction expires effective January 1, 2014.

Dependent children who terminated from the Plan prior to January 1, 2011 (including those who elected COBRA continuation coverage) may re-enroll as dependents during the Plan’s annual Open Enrollment period or during a minimum 30-day special open enrollment period which occurs on or after September 23, 2010.

A child who is not a biological child, step-child, adopted child (or child placed with a covered Employee in anticipation of adoption), or a foster child will not be subject to the limiting age of 26 years, or to the marital status, financial dependence, residence, or student status provisions of the federal Affordable Care Act.

2) Dependent Students who are over 19 years of age but under 25 who receive more than half of their support from the Employee or retiree and who are enrolled as full-time students and attending an accredited secondary College or University, school or institution of learning. Full-time status is defined by the College, University, school or institution; graduate-level students on internships are considered to be full-time students if the institution validates full-time status.

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.

Your unmarried Dependent child between the ages of 19 and 25 for purposes of eligibility shall be considered to still be a student for a period of 120 days prior or subsequent to graduation from, entrance to or enrollment/re-enrollment in high school or a College or University providing the student meets all other eligibility requirements.

Your Unmarried Dependent child, between the ages of 19 and 25 who previously was

Your unmarried Dependent child between the ages of 19 and 25 who previously was
not eligible for benefits or had benefits terminated and who returns to a full-time student status, 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, providing the student meets all other eligibility requirements.

Please Note
Eligibility for child attending school as a full time student will terminate at 12:01 a.m. on the date of his/her 25th birthday or the date at the end of student extension after disability. When eligibility ends, the child could qualify for Continuation of Coverage under COBRA shown later in this section.

3) If age 19 years or older but under age 25 and attending an accredited College or University on a full-time basis prior to the disability with the intention to resume full-time enrollment after the disability ends, eligibility will continue pending medical certification.

Effective January 1, 2010, federal law (“Michelle’s 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.

4) Disabled Child who is incapable of self-support by reason of permanent or long term mental or physical disability and who became so disabled before reaching the limiting age. The eligibility of such a Dependent should be established as early as possible. This should be done at the time of your initial enrollment. If your Dependent enrolled child under the limiting age becomes disabled and incapable of self-support after the time of your initial enrollment, you should advise the SCSD Benefits Office immediately. Eligibility must again be established at the time of the birthday on which he or she reached the limiting age.

Please Note
To obtain Plan Coverage for disabled Dependents or full-time students, you will be required to document, at least annually, appropriate certification of this fact. Failure to provide the Syracuse City School District with this information when requested will result in that particular Dependent child being removed from enrollment and eligibility for benefits under the Benefits Plan until proof is provided supporting continued eligibility under the Benefits Plan.

c. Child Definition - Child or children means:

1) The Employee or retiree's biological child, stepchild, legally adopted child, a child placed for adoption, a pre-adoptive newborn, or a foster child who is under the limiting age of 26 years;

   a) Any unmarried child placed for adoption before the child reaches age 18. The
term placed for adoption means a child placed in the Employee or retiree’s home and the Employee or retiree’s assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. This eligibility ends when such legal obligation terminates. Proof of preadoption status will be required by the SCSD Benefits Office to establish eligibility. Once the child is legally adopted, he or she retains eligibility as a legally adopted child as shown above.

b) Pre-adoptive newborn from the moment of birth under a family Plan when all of the following conditions are met:

i) You enroll the child that you intend to adopt in a family Plan within 30 days of the birth and applicable family Contribution is made, if any;

ii) You take physical custody of the child upon discharge from the Hospital or Birthing Center; and

iii) Within 30 days of the child’s birth, you file a petition to adopt or for temporary legal guardianship under New York State Domestic Relations Law.

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

2) Any child of an Active Employee’s domestic partner who permanently resides in the Employee’s home and who is either under the limiting age of 19 years or who qualifies as a Dependent Student; or

3) Any other child supported by the Employee or retiree, or the Spouse of the Employee or retiree, or child of an Active Employee’s domestic partner and permanently residing in the Employee or retiree’s home, provided the support and residence commenced before the child reached age 19, and who is either under the limiting age of 19 years or who qualifies as a Dependent Student.

Section I – Summary of Benefits, subsections B. and E. are amended to remove the reference to lifetime benefit maximum.

B. Preventive Care Expense Benefits

Note: All benefits for Covered Services are based on Allowable Fees. When using a Network Provider you need only pay applicable Copayments. If you use an Out of Network Provider, you are responsible for payment of applicable Deductible and any charges more than the Usual, Customary and Reasonable (UCR) allowance. Some services are only Covered when obtained from a Network Provider and will not be paid if obtained from an Out of Network Provider. These services will be so noted.

<table>
<thead>
<tr>
<th>Section</th>
<th>Preventive Covered Services</th>
<th>Network</th>
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Syracuse City School District Health Benefit Plan Appendix C 07/01/06

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### Preventive Covered Services

<table>
<thead>
<tr>
<th>Section</th>
<th>Preventive Covered Services</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV B 1</td>
<td>Well Child Care</td>
<td>Benefits are provided for eligible children from birth through age 18. Includes age appropriate well child care, usual related tests and immunizations.</td>
<td></td>
</tr>
<tr>
<td>IV B 4</td>
<td>Routine Physician Nursery Care</td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charges, after Deductible</td>
</tr>
<tr>
<td></td>
<td>Well Child Care</td>
<td>Full Network Benefits</td>
<td>80% of Usual, Customary and Reasonable Charges (UCR), after Deductible</td>
</tr>
</tbody>
</table>

### E. Major Medical Expense Benefits

**Deductibles, Copayments and Benefit Maximum:** *Unless shown otherwise, the Plan Deductibles and percentage Copayments apply to Out of Network Allowable Fees. The Network Copayments apply only when shown for Covered Network services.*

**Calendar Year Deductible:** The part of the Allowable Fees that the participant must pay each Calendar Year. Benefits are based on the balance.

**Percentage Copayment:** The portion of Allowable Fees paid by the Plan (usually after Deductible is taken).

**Network Copayment:** The portion of the Network allowable fee paid by the Employee or retiree. This Copayment does not count toward Major Medical Deductibles or Percentage Copayments. **Per Event:** Means all services rendered by the same Provider on the same day.

**Calendar Year:** The most the Plan will pay per Covered Person for Major Medical Expense Benefits. Except as shown otherwise, all Covered Expenses are subject to the Major Medical Calendar Year Deductible and Copayment limits.

### Major Medical Expenses

<table>
<thead>
<tr>
<th>Major Medical Expenses</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>Does not apply.</td>
<td>Does not apply.</td>
</tr>
</tbody>
</table>

### Section I – Summary of Benefits, subsections B. is further amended to eliminate the $50 calendar year maximum on Routine Adult Care:

| Adult Routine or Well Care | Benefits are provided for limited routine care services (preventive) not due to Illness or Injury. | }
| IV B 3 | Adult Physical Exam (Limited to active Employees age 50 or older, not payable for any other Covered Persons) | Full Network Benefits *once per Calendar Year* for exam only any combination of Network and Out of Network Providers. Related diagnostic tests are Covered separately. | 80% of Usual, Customary and Reasonable Charges (UCR), after Deductible, *once per Calendar Year* for exam only any combination of Network and Out of Network Providers. Related diagnostic tests are Covered separately. |

**Section IV – Covered Services, subsection E. Major Medical Expense Benefits (first paragraph) is amended to read:**

**E. Major Medical Expense Benefits**

Unless shown otherwise, Allowable Fees for Covered Services are subject to the Calendar Year Deductible, Copayment limit, and lifetime benefit maximums, *if any*. Refer to **Section I - Summary of Benefits** under **Major Medical Expense Benefits** for details.

**Section II – Eligibility and Enrollment, subsection E. End of Coverage (last paragraph) is amended to read:**

**E. End of Coverage**

Plan Coverage ends for you and your Eligible Dependents when you no longer meet the eligibility requirement for Plan enrollment. Coverage for a Dependent ends when he or she no longer meets the Dependent eligibility requirements for Plan enrollment.

If you are no longer eligible, your individual or family Coverage would terminate at 12:01 AM on the 1st or 16th day of the next month following the date of the last payroll period in which contributions for coverage were made. Examples: A person who made two payroll deductions for coverage in November would have Plan Coverage terminated at 12:01 AM on January 1. A person who made only one payroll deduction for coverage in November would have Plan Coverage terminated at 12:01 AM on December 16. Ten-month Employees who leave the Syracuse School District after June 30 or fail to report for work in September will have their Plan Coverage terminated at 12:01 A.M. on the date the child no longer meets eligibility requirements (i.e., child's marriage, reaches age limit, divorce of a Spouse).

However, you or your Eligible Dependents could be eligible for **Continuing Coverage under COBRA** shown later in this section.

If you fail to make a required contribution, Coverage will terminate at the end of your prepaid Coverage period.

*Coverage may be stopped if you or your Dependents knowingly submit a claim, or allow a claim to be submitted with false information, or conceal any facts, that could affect the outcome of a claim*
determination; 30 days advance notice of rescission will be provided. In this case, you or your Dependents cannot continue Coverage under COBRA.

Appendix B – Definitions is amended to add:

**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.

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

Appendix C – Plan Exclusions, section 35. is clarified as shown; this is not a change in benefit:

**35. Facility Employees.** Separate charges for services by members of the staff employed by a Hospital, Skilled Nursing Facility, Convalescent Facility, Rehabilitation Facility, or by any Inpatient facility where care is received. *Exception: Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.*
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 010  
**Amendment Effective Date:** January 1, 2012  
**Nature of Amendment:** To add coverage for same-gender Spouses effective January 1, 2012 and remove coverage for domestic partners of active employees effective December 31, 2011

**Section II Eligibility and Enrollment, subsection A. Eligibility for Plan Enrollment, paragraph 3. c. is amended as follows:**

3. **Dependents, c. Child Definition** is amended to delete 2) *(shown below for reference only)*

   2) Any child of an Active Employee’s domestic partner who permanently resides in the Employee’s home and who is either under the limiting age of 19 years or who qualifies as a Dependent Student; or

3. **Dependents, c. Child Definition, 3)** is amended to read:

   3) Any other child supported by the Employee or retiree, or the Spouse of the Employee or retiree, and permanently residing in the Employee or retiree's home, provided the support and residence commenced before the child reached age 19, and who is either under the limiting age of 19 years or who qualifies as a Dependent Student.

**Section II – Eligibility and Enrollment, A. Eligibility for Plan Enrollment, paragraph 3. is amended to remove d. *(shown below for reference only)*:**

**d. Domestic Partners of Active Employees,** according to the following criteria established by the Board of Education:

1) The Active Employee and same-sex domestic partner individuals have an exclusive mutual commitment, similar to that of marriage, as evidenced by a Declaration of Domestic Partnership;

2) The individuals are each other’s sole domestic partner and intend to remain so indefinitely;

3) Neither partner is legally married to another person, and the Employee nor domestic partners cannot be legally married to each other in New York State;

4) Neither individual is related by blood to a degree of closeness which would otherwise prohibit legal marriage in New York State;
5) The Employee and domestic partner are at least eighteen (18) years of age and are legally competent to contract;
6) The Employee and domestic partner are currently residing together and have resided together in a common household for at least eighteen (18) consecutive months and intend to reside together indefinitely;
7) Either (1) the individuals have never previously been in the status of domestic partner in any jurisdiction, or (2) at least eighteen (18) months have elapsed since the termination of a Declaration of Domestic Partnership, Affidavit of Domestic Partnership, or its equivalent in any jurisdiction (unless the reason for termination was the death of the other partner);
8) The Employee and domestic partner share joint responsibility for their common welfare and financial obligations demonstrated by the existence of a domestic partner agreement and at least three (3) other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable power of attorney or health care proxy, co-parenting agreement, or an adoption agreement.
9) The Employee must notify SCSD Benefits Department in writing through a Statement of Termination of Domestic Partnership within thirty (30) days. The benefit coverage for the former domestic partner will terminate immediately upon notification. A domestic partner is not a Qualified Beneficiary under COBRA.

The SCSD Benefits Office can answer questions concerning coverage for domestic partners.

Appendix B – Definitions, Dependent and Spouse are amended to read:

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

SPOUSE - The legal wife or husband of the eligible Employee or retiree. The definition of Spouse also includes your same-gender partner in your marriage that was legally performed in New York State or another jurisdiction.

If an Employee has a same-gender spouse in a marriage that was legally performed in New York State or another jurisdiction, the Plan allows HIPAA special enrollment rights and COBRA-like continuation of coverage, similar to an opposite-gender spouse who is eligible under federal law. Also, an Employee may be eligible to continue coverage during a federally mandated family and medical leave of absence due to a same-gender spouse.
The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

**Amendment Number:** R 2006 - 011  
**Amendment Effective Date:** January 1, 2013  
**Nature of Amendment:** To comply with the provisions of the federal Wellstone Act regarding parity in benefits for treatment of mental health and substance abuse

### Section I – Summary of Benefits, subsections C., D., and E. are amended to read:

#### C. Hospital Expense Benefits (HEB)

<table>
<thead>
<tr>
<th>Section</th>
<th>HEB Covered Services</th>
<th>Network Benefits and Out-of Network Benefits</th>
</tr>
</thead>
</table>
| IV C 1 a | Acute Care General Hospital | • Bargaining units 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12 only: $100.00 copayment per admission  
**Full Benefits for 365 benefit days per Spell of Illness.**  
• All other groups: **Full Benefits for 365 benefit days per Spell of Illness.**  
Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. **Additional Coverage is available under Major Medical Expense Benefits.** |
| IV C 7  | Psychiatric Facility | **Coverage is limited to 365 days per Spell of Illness for stays in private or government-owned (public) Psychiatric Facilities.**  
Stays in an Acute Care General Hospital are Covered separately.  
Benefit days count toward the **365-day limit** for Acute Care General Hospital.  
Full Benefits when approved through the Benefit Management Program. Additional Coverage is available under Major Medical Expense Benefits.  
**Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary.**  
For treatment in an Acute Care General Hospital, see Mental Health Disorder Inpatient Limits. |
### Section IV C 8

**Substance Use Disorder Facility Inpatient**

- **Network Benefits and Out-of-Network Benefits**
  - Certified Acute Care General Hospitals only:
    - Bargaining units 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12 only:
      - $100.00 copayment per admission
      - **Full Benefits for 365 benefit days per Spell of Illness.**
    - All other groups:
      - **Full Benefits for 365 benefit days per Spell of Illness**
  - Other certified Substance Abuse Facilities:
    - **Full Benefits for 365 benefit days per Spell of Illness**
  - Services and Plan of Care must be approved through the Managed Care Program. Semi-private room limit. Additional benefits are available under Major Medical Expense Benefits.
  - Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary.

### Section IV D3

**Inpatient Physician Visits Attending Physician**

- Coverage for visits is limited to the number of inpatient days approved for benefits through the Benefits Management Program.
- **Full Network Benefits**
- 100% of Usual, Customary, and Reasonable (UCR) Charges up to one visit per day for attending Physician. Limit 120 days per Spell of Illness. Additional Coverage is available under Major Medical Expense Benefits.

### Section IV D4

**Mental Illness Visits**

- **Network Benefits**
- Out of Network
E. Major Medical Expense Benefits

<table>
<thead>
<tr>
<th>Section</th>
<th>Major Medical Covered Services</th>
<th>Network Benefits</th>
<th>Out of Network Benefits</th>
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<tbody>
<tr>
<td>IV E 10</td>
<td>Inpatient Mental Health Disorder - Psychiatric Facility</td>
<td>80%, after Deductible, for Covered Services after Hospital Expense Benefits exhausted. In Network and Out of Network expenses count toward the percentage Copayment Limit.</td>
<td></td>
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<tr>
<td>IV E 10</td>
<td>Outpatient Mental Health Disorder including Partial Hospitalization</td>
<td>Current Copayment per event. Unlimited visits</td>
<td>80% of Usual, Customary and Reasonable (UCR) Charge, after Deductible Percentage Copayment limit does apply. Unlimited visits</td>
</tr>
<tr>
<td>IV E 18</td>
<td>Inpatient Substance Use Disorder</td>
<td>80%, after Deductible, for Covered Services after Hospital Expense Benefits exhausted. In Network and Out of Network expenses count toward the percentage Copayment Limit.</td>
<td></td>
</tr>
</tbody>
</table>

Section III – Benefit Management Program, subsection E., shown below for reference only, is deleted in its entirety:

E. Alcohol/Substance Abuse Facility-Outpatient Care Review

The facility or agency must submit a care plan to the POMCO Managed Care unit at the time of initial assessment and before treatment begins. The Claims Administrator will review the care plan and advise the facility or agency and you whether Coverage is available under the Plan. If care plan is not submitted for preapproval or if the care plan is not approved for Plan Coverage, benefits will not be paid.

Section IV - Covered Services, subsection C. Hospital Expense Benefits, paragraphs 7. and 8. are amended to read:

7. Psychiatric Facility. Refer to Section I - Summary of Benefits for benefit day limits for any combination of Psychiatric Facility and acute care Hospital stays.

Phone calls are required by you before Inpatient admissions to a Psychiatric Facility. Refer to Section III - Benefit Management Program for instructions.

a. Private Psychiatric Facility. Inpatient Care is Covered when ordered by the attending Physician when the patient requires Inpatient Care to protect himself or others or where the course of treatment can only be carried out on an Inpatient basis.

Services must be Medically Necessary and pre-approved for Coverage through the Benefit Management Program.

Room and board charges billed for the date of discharge are not Covered. Benefits will
not be paid for residential care, Custodial Care, education or training. **Additional Coverage is available under Major Medical Expense Benefits.** Separate charges for staff Physicians, nurses and other facility employees are not Covered.

**b. Government-Owned Psychiatric Facility.** Benefits are available for care in a public (government-owned) psychiatric facility as described under a. above.

8. Alcohol/Substance Abuse Facility.

a. **Inpatient**

Phone calls are required by you before Inpatient admissions. Refer to Section III - Benefit Management Program for instructions.

Benefits are available for Inpatient diagnosis and treatment of Substance Use Disorders rendered and billed by a certified Alcohol/Substance Abuse Facility when preapproved through the Benefit Management Program. Benefits will not be paid if the Claims Administrator does not approve Coverage for any portion of an Inpatient stay. Days count toward the General Hospital per Spell of Illness maximum. If a private room used, charges more than the Average Semi-Private Rate will be excluded. Room and board charges billed for the date of discharge are not Covered. Benefits will not be paid for residential care, Custodial Care, education or training.

Copayments could apply to admissions to Acute Care General Hospitals for Substance Use Disorder treatment; refer to Section I - Summary of Plan Benefits for details.

Refer to Section I - Summary of Benefits for benefit limits. **Additional Coverage is available under Major Medical Expense Benefits.** Separate charges for staff Physicians, nurses or other employees are not Covered.

b. **Outpatient.** Benefits are available for eligible Enrollee and Eligible Dependents for Outpatient services rendered by a certified alcohol or certified Substance Abuse Facility (freestanding agency or facility or a Hospital center) for the diagnosis and treatment of Substance Use Disorders. Each visit must consist of at least one of the following: individual or group counseling; activity therapy; and diagnostic evaluations by a Doctor or other licensed professional to decide the nature and extent of the patient’s Illness. Benefits are not payable for visits that consist primarily of participation in programs of a social, recreational, or companionship nature. The employees of the facility must render services provided by the facility.

**Partial Hospitalization is Covered.**

*Counseling for the affected person’s Covered family members is covered.* Family member visits are only payable for services rendered for enrolled family members under a family plan. One visit per day will be allowed, except a family member counseling visit that takes place separately from the patient’s individual visit on the same day. The same allowable amount will be paid for a family member visit, whatever the number of family members attending the counseling session. **Additional Coverage is available under Major Medical Expense Benefits.**
Section IV - Covered Services, subsection D. Medical/Surgical Expense Benefits, paragraph 4. is amended to read:

4. Mental Illness Inpatient visits/Acute Care General Hospital or Psychiatric Facility. Coverage is limited to visits during room and board benefit days approved for Inpatient Mental Illness under Hospital Expense Benefits. Coverage is limited to one visit each day up to 120 days per Spell of Illness for acute care General Hospital or Psychiatric Facility visits. In no event, will the Plan pay more than 120 Inpatient visits per Spell of Illness for any combination of acute care General Hospital or Psychiatric Facility stays. Additional Coverage is available under Major Medical Expense Benefits.

Section IV - Covered Services, subsection E. Major Medical Expense Benefits, paragraphs 1.a., 2.a., and 10. are amended to read:

1. Acute Care General Hospital.

   a. Inpatient Services. After Hospital Expense Benefits are exhausted, this benefit becomes available for acute care Inpatient treatment of Illness or Injury. This benefit is also available for Mental Health Disorder care. Coverage includes room and board and ancillary charges on the same basis as shown under Hospital Expense Benefits. If a private room is used, you will be responsible for charges more than the average semi-private room rate unless private room is ordered by the attending Physician and found Medically Necessary according to Plan provisions. Use of private room that is primarily at the request of the patient or family member will be limited to semi-private rates even if ordered by the Physician. Coverage for Physicians and private duty nursing expenses is considered separately.

2. Doctor Services

   a. Inpatient Physician Care. After Medical/Surgical Expense Benefits are exhausted, benefits become available for Inpatient Physician visits during an approved stay in a Hospital, Skilled Nursing Facility, or Psychiatric Facility. These benefits are Covered except surgeons’ post operative or post obstetrical care. The Physician in charge of the treatment for conditions other than Surgery or obstetrical care will usually be Covered for one visit per day under this benefit. Additional Physicians or Physician visits will be considered when found Medically Necessary according to Plan provisions. For example: When patient’s Illness is so critical or serious it requires more attention by the Doctor, or complications during post-operative care. Care by more than one Physician will be considered when each Provider gives medically required treatment for separate and different conditions. Benefits are not provided for Physician visits for treatment found to be Custodial Care.

10. Mental Health Disorder.

   a. Inpatient Care – Psychiatric Facility. After Hospital Expense Benefits are exhausted, this benefit becomes available for Inpatient treatment of Mental Health Disorders in a Hospital or Psychiatric Facility.
b. Outpatient Care. Alcohol or Drug addiction services are not Covered under this benefit. Refer to Substance Use Disorders under Hospital Expense Benefits shown previously in this section.

Benefits are available for Mental Health Disorder care rendered by a licensed psychiatrist (medical Doctor), licensed clinical psychologist, accredited Certified Psychiatric Social Worker or a Certified Psychiatric Nurse when found Medically Necessary according to Plan limitations. Treatment must be directed at a diagnosed Mental Health Disorder.

Partial Hospitalization is Covered.

Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy which includes the satisfaction of requirements for professional training.
Section IV, subsection E. Major Medical Expense Benefits is further amended to add paragraph 18. to read:

18. Alcohol/Substance Abuse Facility - Inpatient Care. After Hospital Expense Benefits are exhausted, this benefit becomes available for Inpatient treatment of Substance Use Disorders rendered and billed by a certified Alcohol/Substance Abuse Facility.

Appendix B – Definitions – Mental Health Care, Psychiatric Facility, Spell of Illness, and Substance Abuse Facility are amended to read:

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

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

MENTAL ILLNESS - See Mental Health Disorder.

PSYCHIATRIC FACILITY: A private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator as an inpatient facility for the treatment of Mental Health Disorders and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorders.

SPELL OF ILLNESS - A period beginning with the first allowable care for treatment of any Illness or Injury as an Inpatient in a Hospital, Skilled Nursing Facility, Birthing Center, Psychiatric Facility, or Substance Abuse Facility 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, Birthing Center, Psychiatric Facility, or Substance Abuse Facility.

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

Appendix B – Definitions is further amended to add Partial Hospitalization and Substance Use Disorder to read:

PARTIAL HOSPITALIZATION (PHP) program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health 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 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 at least 20 hours per week and no charge is made for room and board. Partial Hospitalization also encompasses partial hospitalization programs that provide overnight boarding.

**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.

*Regardless of any limitations on benefits Substance Use Disorder 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.*

**Appendix C - Plan Exclusions, paragraph 22. is amended to read:**

**22. Non-Acute Facilities.** Services, supplies and/or prescription drugs rendered in a place of rest, a place for the aged, a nursing home or in an education facility, a place mainly for care of alcoholism, drug addiction, mental disorders or tuberculosis unless the facility and care rendered meets Plan requirements for Skilled Nursing Facility Coverage, or Substance Abuse Facility Coverage and *Psychiatric Facility Coverage* for Inpatient Mental Illness care.
Syracuse City School District Health Benefits Plan
Restated MPD of July 2006
Plan Amendment

The Syracuse City School District has adopted and amended the following provisions for the self-funded Syracuse City School District Health Benefits Plan.

Amendment Number: R 2006 - 012
Amendment Effective Date: January 1, 2013
Nature of Amendment: To apply an inpatient copayment for union groups 00 and 3 (a $100 copayment will apply to all groups - 00, 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and SV)

Section I – Summary of Benefits, subsections C. is amended to read:

C. Hospital Expense Benefits (HEB)

<table>
<thead>
<tr>
<th>Section</th>
<th>HEB Covered Services</th>
<th>Network Benefits and Out-of Network Benefits</th>
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</table>
| IV C 1 a | Acute Care General Hospital | • All groups: $100.00 copayment per admission  
• Full Benefits for 365 benefit days per Spell of Illness.  
Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. Date of discharge is not allowable. Additional Coverage is available under Major Medical Expense Benefits. |
|          | Inpatient Medical/Surgical, Maternity | |
| IV C 8   | Substance Use Disorder Facility Inpatient | • All groups: $100.00 copayment per admission  
• Full Benefits for 365 benefit days per Spell of Illness.  
Certified Acute Care General Hospitals only:  
Other certified Substance Abuse Facilities:  
• Full Benefits for 365 benefit days per Spell of Illness.  
Services and Plan of Care must be approved through the Managed Care Program. Semi-private room limit. Additional benefits are available under Major Medical Expense Benefits.  
Private room limited to semi-private rates unless ordered by the attending Physician and found Medically Necessary. |