SYRACUSE CITY SCHOOL DISTRICT HEALTH BENEFITS PLAN

SUMMARY PLAN DESCRIPTION
FOR
MEDICAL AND PRESCRIPTION DRUG BENEFTS
UNDER THE
PPO OPTION

Effective: July 1, 2019,unless otherwise stated herein

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INTRODUCTION

This summary plan description (SPD) describes certain components under the PPO Option of the Syracuse City School District Health Benefits Plan (the "Plan"), effective as of July 1, 2019,unless otherwise stated herein.

Syracuse City School District (the "Employer" or "Plan Sponsor") fully intends to maintain the Plan indefinitely. However, the Plan Sponsor has the general right to amend or terminate the Plan, in whole or in part, at any time.

You should carefully review this document for a complete understanding of the benefits available to you, as well as your responsibilities under the Plan. The benefits described in this SPD are provided under a written plan document adopted by the Plan Sponsor. If the terms of this SPD conflict with the terms of the plan document, the terms of the plan document will control, unless otherwise required by law.

The Plan helps to provide financial security for you and your family by offsetting some of the financial costs that may arise as a result of an Illness or Injury. The Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

The Plan is not a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Questions regarding the Plan's status may be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.

The Plan is not a contract of employment between you and the Employer and does not give you the right to be retained in the service of your Employer. The Plan Sponsor has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the terms and conditions of any relevant collective bargaining agreements.

SYRACUSE CITY SCHOOL DISTRICT

Dated: June 27, 2021

By: Jennifer M. Wells
Name: Jennifer M. Wells
Title: Director of Employee Services

MEDICAL SCHEDULE OF BENEFITS - PPO OPTION

	PARTICIPATING PROVIDER (Subject to the Allowed Amount)	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount)
PLAN YEAR DEDUCTIBLE		
Individual	$0	$75
Family	$0	$225
If you have family coverage, once a person within a family has satisfied the individual Non-Participating Provider Deductible above, the Plan will begin to pay any Covered expenses for Non-Participating Providers for that individual for the Plan Year. Once the entire family Non-Participating Provider Deductible above has been satisfied, the Plan will begin to pay any Covered expenses for Non-Participating Providers for any covered family member for the Plan Year.		
PLAN YEAR OUT-OF-POCKET LIMIT		
Individual	$7,150	$7,150
Family	$14,300	$14,300
If you have family coverage, once a person within a family has paid $7,150 (for Participating Providers) or $7,150 (for Non-Participating Providers) in Coinsurance, Copayments, and Deductibles in a Plan Year, the Plan will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person.		
If you use a combination of Participating Providers and Non-Participating Providers, your Out-of-Pocket Limits are separate amounts and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for Participating Providers and Non-Participating Providers separately. The amounts you pay towards satisfaction of the Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Participating Provider Out-of-Pocket Limit.		

MEDICAL BENEFITS – PPO OPTION		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Advanced Imaging Services (Outpatient) (MRI, PET scans, CT scans, and nuclear medicine)		
Facility services	$15 Copayment	$15 Copayment
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Allergy Services		
Testing	$15 Copayment	20% Coinsurance, after Deductible
Treatment (including serum)	$0 Copayment	20% Coinsurance, after Deductible
Ambulance Services		
Pre-hospital emergency services	$0 Copayment	$0 Copayment
Transportation		
Ground ambulance	$0 Copayment	$0 Copayment
Air ambulance	$0 Copayment	$0 Copayment
Water ambulance	$0 Copayment	$0 Copayment
Inter hospital	$0 Copayment	$0 Copayment
Ambulatory Surgical Center		
Facility services	$0 Copayment	$0 Copayment
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Anesthesia Services (all settings)	$0 Copayment	$0 Copayment
Breast Pump	$0 Copayment	20% Coinsurance, after Deductible
Benefit Limitation	Limited to one (1) rental or purchase per pregnancy resulting in a live birth. (Participating Providers and Non-Participating Providers combined)	
Cardiac Rehabilitation (Outpatient)		
Facility services	$0 Copayment	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Plan Year maximum	54 visits (Participating Providers and Non-Participating Providers combined).	
Chemotherapy (Outpatient)		

Facility services	20% Coinsurance	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Chiropractic Care	$15 Copayment	20% Coinsurance, after Deductible
Cochlear Implants	$0 Copayment	20% Coinsurance, after Deductible
Colonoscopies (Diagnostic)		
Facility services	$15 Copayment	20% Coinsurance, after Deductible
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Dialysis (Outpatient)		
Facility services	$0 Copayment	20% Coinsurance, after Deductible
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Durable Medical Equipment	$0 Copayment	20% Coinsurance, after Deductible
Plan Year maximum	Compression stockings are limited to four (4)	
Electroshock Therapy	$0 Copayment	20% Coinsurance, after Deductible
Emergency Services		
Emergency Medical Condition		
Facility services	$100 Copayment*	$100 Copayment*
Professional services	$0 Copayment	$0 Copayment
Note: The Copayment is waived if you are admitted to the Hospital as an inpatient		
Non-Emergency Medical Condition		
Facility services	20% Coinsurance	20% Coinsurance, after Deductible
Professional services	Not Covered	Not Covered
Foot Orthotics	$0 Copayment	20% Coinsurance, after Deductible
Genetic Testing (effective: January 1, 2021)	$15 Copayment	20% Coinsurance, after Deductible
Hearing Evaluations		
Diagnostic	$15 Copayment	20% Coinsurance, after Deductible
Home Care	$0 Copayment	$0 Copayment
Plan Year maximum	40 visits (Participating Providers and Non-Participating Providers combined)	
Home Infusion Therapy	$0 Copayment	$0 Copayment
Hospice Care		
Inpatient	$0 Copayment	$0 Copayment
Outpatient	$0 Copayment	$0 Copayment

Bereavement Counseling	$0 Copayment	$0 Copayment
Infusion Therapy		
Facility services	20% Coinsurance	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Inpatient Hospital Services		
Facility services	$100 Copayment	$100 Copayment
Professional services (except physician consultation)	$0 Copayment	$0 Copayment
Professional services: Physician consultation	$0 Copayment	20% Coinsurance, after Deductible
Benefit limitation	Professional services are limited to one (1) visit per specialty area per day of inpatient stay.	
In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g))	$0 Copayment	$0 Copayment
Lab and Pathology (Outpatient)		
Professional services		
Diagnostic	$15 Copayment	20% Coinsurance, after Deductible
Routine	$0 Copayment	$0 Copayment
Facility services		
Diagnostic	$15 Copayment	$15 Copayment
Routine	$0 Copayment	$0 Copayment
Mammograms (Diagnostic)		
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Facility services (except 3D mammogram)	$15 Copayment	$15 Copayment
Facility services: 3D mammogram	$15 Copayment	20% Coinsurance, after Deductible
Maternity Care (Professional Services)		
Prenatal/post-natal care that is a Preventive	$0 Copayment	20% Coinsurance, after Deductible

Service*		
Prenatal/post-natal care that is not a Preventive Service*	$0 Copayment	20% Coinsurance, after Deductible
Delivery (physician or midwife)	$0 Copayment	$0 Copayment
Medical Supplies	$0 Copayment	20% Coinsurance, after Deductible
Mental Health and Substance Use Services		
Inpatient services	$100 Copayment	$100 Copayment
Outpatient services	$15 Copayment	20% Coinsurance, after Deductible
Newborn Nursery Care - Routine		
Facility services	$0 Copayment	20% Coinsurance, after Deductible
Professional services	$0 Copayment	$0 Copayment
Nutritional Therapy	$15 Copayment	20% Coinsurance, after Deductible
Observation Stays		
Inpatient	$100 Copayment	$100 Copayment
Outpatient	20% Coinsurance	20% Coinsurance, after Deductible
Orthotics	$0 Copayment	20% Coinsurance, after Deductible
Office Visits	$15 Copayment	20% Coinsurance, after Deductible
Physical Rehabilitation - (Inpatient)		
Facility services	$100 Copayment	$100 Copayment
Preadmission Testing	$15 Copayment	20% Coinsurance, after Deductible
Preventive Care		
Adult annual physical examinations	$0 Copayment	$0 Copayment
Plan Year maximum	One (1) exam (Participating Providers and Non-Participating Providers combined). Includes routine tests, labs and x-rays performed in conjunction with and within 30 days of a routine physical exam	
Adult immunizations	$0 Copayment	$0 Copayment
Bone density testing	$0 Copayment	20% Coinsurance, after Deductible
Colonoscopies	$0 Copayment	$0 Copayment
Contraceptive methods and counseling	$0 Copayment	$0 Copayment
COVID-19 Vaccine Effective as of 15	$0 Copayment	$0 Copayment

business days after a recommendation is made by the U.S. Preventive Services Task Force or CDC Advisory Committee on Immunization Practices		
Gynecological services/well woman exams	$0 Copayment	$0 Copayment
Plan Year maximum	One (1) exam (Participating Providers and Non-Participating Providers combined)	
Mammograms	$0 Copayment	$0 Copayment
Plan Year maximum	One (1) exam per for Covered Persons age 35 and over.	
Elective sterilization		
Female	$0 Copayment	20% Coinsurance, after Deductible
Male	Subject to applicable cost-share based on Covered Service provided	Subject to applicable cost-share based on Covered Service provided
Prostate cancer screenings	$0 Copayment	$0 Copayment
Plan Year maximum	One (1) exam (Participating Providers and Non-Participating Providers combined)	
Smoking cessation-PPACA preventive service only	$0 Copayment	$0 Copayment
Plan Year maximum	Eight (8) visits	
Well child visits and immunizations	$0 Copayment	$0 Copayment
	Includes routine tests, labs and x-rays performed in conjunction with and within 30 days of a routine physical exam	
Preventive care that is considered a Preventive Service	$0 Copayment	20% Coinsurance, after Deductible
Preventive care that is not considered a Preventive Service	Subject to applicable Cost-Sharing based on Covered Service provided.	Subject to applicable Cost-Sharing based on Covered Service provided.
Please refer to the Preventive Services provision under the Additional Benefits section of this SPD for additional details.		
Private Duty Nursing	$0 Copayment	0% Coinsurance, after Deductible
Prosthetic Devices		

External	$0 Copayment	20% Coinsurance, after Deductible
Hair prosthetics	$0 Copayment, up to $750	$0 Copayment, up to $750
Lifetime maximum	Hair prosthetics are limited to one (1) (Participating Providers and Non-Participating Providers combined)	
Implanted	$100 Copayment	$100 Copayment
Mastectomy prosthetics	$0 Copayment	20% Coinsurance, after Deductible
Pulmonary Rehabilitation (Outpatient)		
Facility services	$0 Copayment	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Lifetime maximum	36 visits (Participating Providers and Non-Participating Providers combined)	
Qualified Clinical Trial Expenses	$0 Copayment	Not Covered
Radiation Therapy (Outpatient)		
Facility services	$0 Copayment	$0 Copayment
Professional services	$0 Copayment	$0 Copayment
Respite Care	$0 Copayment	$0 Copayment
Rehabilitation/Habilitation Services (Outpatient)		
Physical Therapy		
Facility services	$15 Copayment*	20% Coinsurance, after Deductible*
Professional services	$15 Copayment*	20% Coinsurance, after Deductible*
***Note: The Copayment, Coinsurance and Deductible are waived for physical therapy rendered within six (6) months of a Covered hospitalization or surgery.**		
Occupational Therapy		
Facility services	$15 Copayment	20% Coinsurance, after Deductible
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Speech Therapy		
Facility services	$0 Copayment	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Skilled Nursing Facility		
Inpatient	$100 Copayment	$100 Copayment
Outpatient	$0 Copayment	20% Coinsurance, after Deductible
Limitations	Not Covered if Medicare is Primary.	
Surgical Procedures		

Inpatient		
Facility services	$100 Copayment	$100 Copayment
Professional services	$0 Copayment	$0 Copayment
Outpatient		
Facility services	$15 Copayment	20% Coinsurance, after Deductible
Professional services	$15 Copayment	20% Coinsurance, after Deductible
Office surgery	$0 Copayment	20% Coinsurance, after Deductible
Telemedicine Program – MD Live	$15 Copayment	Not Covered
Temporomandibular Joint Dysfunction (TMJ)	Subject to applicable Cost-Sharing based on Covered Service provided.	Subject to applicable Cost-Sharing based on Covered Service provided.
Transplant Services	$0 Copayment	20% Coinsurance, after Deductible
Treatment of Diabetes		
Diabetic supplies	$0 Copayment	20% Coinsurance, after Deductible
Benefit note	Coverage for insulin is Covered under the Prescription Drug benefit component of the Plan only. Please refer to the Prescription Drug benefit section of this SPD.	
Diabetic education	$0 Copayment	20% Coinsurance, after Deductible
Diabetic equipment	$0 Copayment	20% Coinsurance, after Deductible
Urgent Care Center		
Facility services	$15 Copayment	20% Coinsurance, after Deductible
Professional services	$0 Copayment	20% Coinsurance, after Deductible
Vision Care- diagnostic eye exams	$15 Copayment	20% Coinsurance, after Deductible
X-Rays (Outpatient)		
Facility services		
Diagnostic	$15 Copayment	$15 Copayment
Routine	$0 Copayment	$0 Copayment
Professional Services		
Diagnostic	$15 Copayment	20% Coinsurance, after Deductible
Routine	$0 Copayment	$0 Copayment

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

	PARTICIPATING PHARMACY (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
PLAN YEAR DEDUCTIBLE	None	Not Covered
PLAN YEAR OUT-OF-POCKET LIMIT (combined with medical)		
Individual	$7,150	Not Covered
Family	$14,300	Not Covered
If you have family coverage, once a person within a family has paid $7,150 (for Participating Providers) or $7,150 (for Non-Participating Providers) in Coinsurance, Copayments, and Deductibles in a Plan Year, the Plan will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person.		
If you use a combination of Participating Providers (including Participating Pharmacies) and Non-Participating Providers (not including Non-Participating Pharmacies), your Out-of-Pocket Limits are separate amounts and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for Participating Providers (including Participating Pharmacies) and Non-Participating Providers (not including Non-Participating Pharmacies) separately. The amounts you pay towards satisfaction of the Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Participating Provider Out-of-Pocket Limit.		
Retail Pharmacy – 30-day supply		
Generic Drug	$2 Copayment	Not Covered
Preferred Brand Name Drug	25% Coinsurance	Not Covered
Non-Preferred Brand Name Drug	25% Coinsurance	Not Covered
Mail Order Pharmacy with Mandatory Maintenance Drugs– 90-day supply**		
Generic Drug	$14 Copayment	Not Covered
Preferred Brand Name Drug	$75 Copayment	Not Covered
Non-Preferred Brand Name Drug	$95 Copayment	Not Covered
***Note: Maintenance Drugs must be obtained through a mail order pharmacy after two (2) fills at a retail pharmacy.*		
Specialty Drugs	Same Cost-Sharing as retail and/or mail order listed above	Not Covered
Preauthorization Requirement: Certain Prescription Drugs require Preauthorization. If you don't get Preauthorization, your Prescription Drug will not be Covered. You can view a list of Prescription Drugs that require Preauthorization by visiting www.caremark.com . You may also request a copy, free of charge by calling customer care toll free at 1-866-626-1083.		
Mandatory Generic. The Plan requires pharmacies to dispense Generic Drugs, when available. If you or your provider chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable Cost-Sharing for the Generic Drug, plus the cost-difference between the Generic Drug and the higher cost drug. This cost difference will not apply to your Out-of-Pocket Limit.		

	PARTICIPATING PHARMACY (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
Formulary: The list that identifies those Prescription Drugs for which coverage may be available under the Plan. This list is subject to periodic review and modification. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.caremark.com or by calling customer care toll free at 1-888-626-1083.		
Specialty Drugs: Specialty drugs must be obtained from the specialty Prescription Drug Designated Pharmacy- CVS Caremark Specialty Pharmacy. For assistance with specialty drugs, you or your physician may call CVS Caremark Specialty Pharmacy at 1-888-626-1083.		

DEFINITIONS

The terms defined in this section have been capitalized throughout this document.

Acute. The onset of disease or injury, or a change in your condition that would require prompt medical attention.

Allowed Amount. With respect to the Prescription Drug benefits provided under the Plan, the Allowed Amount for Participating Provider Prescription Drug benefits is the Prescription Drug Benefit Manager's contractually determined amount before any applicable Coinsurance, Copayment and Deductible Amounts are subtracted.

With respect to the medical benefits provided under the Plan, the Allowed Amount is the maximum amount the Plan will pay for the services or supplies Covered under the Plan, before any applicable Coinsurance, Copayment, and Deductible amounts are subtracted. For the medical benefits, the Allowed Amount is determined as follows:

The Allowed Amount for Participating Providers will be the amount the Plan has negotiated with the Participating Provider, or the Participating Provider's charge, whichever is less. However, when the Participating Provider's charge is less than the amount the Plan has negotiated with the Participating Provider, your Coinsurance, Copayment or Deductible amount will be based on the Participating Provider's charge.

The Allowed Amount for Non-Participating Providers will be determined as follows:

(1) **Facilities in the Service Area.**
For Facilities in the Service Area, the Allowed Amount will be 150 % of the Centers for Medicare and Medicaid Services Prospective Payment System ("CMSPS") amount unadjusted for geographic locality, or the Facility's charge, if less.

If there is no CMSPS amount as described above because of insufficient data or there is no CMSPS rate, the Allowed Amount will be 80% of the average amount negotiated with Facilities that are Participating Providers of the same type as the Non-Participating Provider Facility.

(2) **Facilities outside the Service Area.**
For Facilities outside the Service Area, the Allowed Amount will be 80% of the average amount negotiated with Facilities that are Participating Providers of the same type as the Non-Participating Provider Facility, or the Facility's charge, if less.

(3) **For a Health Care Professional or a Provider of Additional Health Services in the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services in the Service Area, the Allowed Amount will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Health Care Professional or Provider of Additional Health Services charge, if less.

If there is no UCR amount as described above, the Allowed Amount will be 75% of the Health Care Professional or Provider of Additional Health Services charge.

(4) **For a Health Care Professional or a Provider of Additional Health Services Outside the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services outside the Service Area, the Allowed Amount will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Health Care Professional or Provider of Additional Health Services charge, if less.

If there is no UCR amount as described above, the Allowed Amount will be 75% of the Health Care Professional or Provider of Additional Health Services charge.

(5) **Emergency Services or Ground Ambulance.** The Allowed Amount for a Non-Participating Provider for Emergency Services or ground ambulance will be the Non-Participating Provider's charge. You are responsible for any Coinsurance, Copayment or Deductible.

(6) **Air Ambulance.** The Allowed Amount for a Non-Participating Provider for air ambulance will be the lesser of (a) 500% of the Medicare allowed charge, or (b) the Non-Participating Provider's charge.

(7) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Plan uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Plan based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

(8) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowed Amount for a Non-Participating Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Non-Participating Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Non-Participating Provider.

The Non-Participating Provider's actual charge may exceed the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge.

The Plan reserves the right to negotiate a lower rate with Non-Participating Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

Ambulatory Surgical Center. A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Balance Bill, or Balance Billing. When a Non-Participating Provider bills you for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill you for Covered Services.

Brand Name Drug. A Prescription Drug that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) the Prescription Drug Benefit Manager identifies as a Brand-Name Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as a Brand-Name Drug by the Plan.

Calendar Year. The twelve-month period beginning on January 1 and ending on December 31 each year.

Child. Your biological child, legally adopted child (or a child placed with you in anticipation of adoption), stepchild, a child for whom you are a court-appointed legal guardian, and, a child for whom you are required to provide coverage under the Plan pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Procedures for determining a QMCSO may be obtained from the Plan Administrator, upon request and free of charge.

For purposes of this section "a Child placed with you in anticipation of adoption" means a Child who is under the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of such Child.

Claims Administrator. The Claims Administrator is the Medical Claims Administrator and Prescription Drug Benefit Manager.

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

COBRA Beneficiary. A Covered Person who is entitled to and elects to continue health coverage under this Plan in accordance with Section 4980B of the Internal Revenue Code. The term will also include a Child who is born or placed for adoption, with the covered Employee during the period of COBRA coverage.

Coinsurance. Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay directly to a provider. The amount can vary by the type of Covered Service.

Copayment. A predetermined charge, expressed as a fixed amount, which you pay directly to a provider for a Covered Service at the time the service is rendered. The amount can vary by the type of Covered Service.

Cost-Sharing. Amounts you must pay for Covered Services, expressed as Coinsurance, Copayments and/or Deductibles.

Covered Person. A Covered Employee, Retiree and each of his or her Dependents covered under the Plan.

Cover, Covered or Covered Service(s). The Medically Necessary items or services paid for, arranged, or authorized for a Covered Person under the terms and conditions of this Plan.

Deductible. The amount you owe before the Plan begins to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g. a Prescription Drug Deductible) that you owe before the Plan begins to pay for a particular Covered Service. There are special Deductible rules that apply when you have other than individual coverage. See the Deductible provision of the Schedule of Benefits section of this Plan.

Dependent. See the Eligibility section of this Plan.

Designated Pharmacy. A pharmacy that has entered into an agreement with the Prescription Drug Benefit Manager or with an organization contracting on behalf of the Prescription Drug Benefit Manager, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Durable Medical Equipment. Equipment that is:

(1) Designed and intended for repeated use;

(2) Primarily and customarily used to serve a medical purpose;

(3) Generally not useful to a person in the absence of disease or injury; and

(4) Appropriate for use in the home.

Emergency Condition. A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn Child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

Emergency Services. A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn Child (including the placenta).

Employee. A common-law Employee of the Employer, as determined in accordance with the employment records of the Employer.

Employer. Syracuse City School District or any successor thereto.

Essential Health Benefit. An Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following general categories and the items and services Covered within such categories: ambulatory patient services; Emergency Services; Hospitalization; maternity and newborn care; mental health and substance use services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic and disease management; and pediatric services, including oral and vision care.

The determination of what benefits constitute an Essential Health Benefit under this Plan will be made in accordance with the benchmark plan for the state of Utah benchmark plan.

Facility. A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law or, in other states, a similarly licensed or certified Facility. If you receive treatment for a Substance Use Disorder outside of New York State, a Facility also includes one which is accredited by the JCAHO or a national accreditation organization recognized by the Claims Administrator to provide a substance use disorder treatment program.

FMLA. The Family and Medical Leave Act of 1993, as may be amended from time to time.

Formulary. The list that identifies those Prescription Drugs for which coverage may be available under this Plan. This list is subject to periodic review and modification. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.Caremark.com or by calling the number on your ID card.

Generic Drug. A Prescription Drug that 1) is chemically equivalent to a Brand-Name Drug; or 2) that is identified by the Prescription Drug Benefit Manager as a Generic Prescription Drug based on available data resources. Some Prescription Drugs identified as "generic" by the manufacturer, pharmacy, or your Physician may not be classified as a Generic Drug by the Plan.

Genetic Information. Information about an individual's genetic tests, the genetic tests of that individual's family members, the manifestation of disease or disorder in family members of the individual, an individual's request for, or receipts of, genetic services, or the participating in clinical research that includes genetic services by the individual or a family member of the individual, or Genetic Information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual, and the Genetic Information of any embryo legally held by the individual or family member using an assisted reproductive technology. Genetic Information will not be taken into account for purposes of determining eligibility for benefits under the Plan or establishing premium or contribution amounts for coverage under the Plan.

Habilitation Services. Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional. An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavioral analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law (or other comparable state law, if applicable) requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of provider in order to be Covered under this Plan.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency. An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care. Care to provide comfort and support for persons in the last stages of a terminal illness and their families that is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital. A short term, Acute, general Hospital, which:

(1) Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
(2) Has organized departments of medicine and major surgery;
(3) Has a requirement that every patient must be under the care of a Physician or dentist;
(4) Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
(5) If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
(6) Is duly licensed by the agency responsible for licensing such Hospitals; and
(7) Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization. Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Life-Threatening Condition. Any disease or condition from which the likelihood of death is probable unless the course of the disease or the condition is interrupted.

Lifetime Maximum. The maximum benefit payable during an individual's lifetime while Covered under this Plan. This Plan may provide for a Lifetime Maximum benefit for a specific type of Covered Service or treatment. Any Lifetime Maximum will be shown in the Schedule of Benefits section of this Plan.

Maintenance Drug. A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

Medical Claims Administrator. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Plan on behalf of the Plan Sponsor and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.

Medical Necessity or Medically Necessary. See the Medical Necessity and Preauthorization section of this Plan.

Medicare. Title XVIII of the Social Security Act, as amended.

Mental Health Disorder. A Mental Health Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Non-Brand Name Drug. Any Prescription Drug that is not a Generic Drug or a Brand Name Drug.

Non-Participating Pharmacy. A pharmacy that has not entered into an agreement with the Prescription Drug Benefit Manager to provide Prescription Drugs to Covered Persons. The Plan will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy.

Non-Participating Provider. A Facility, Health Care Professional, or a Provider of Additional Health Services that does not have a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide services to you. You will pay higher Cost-Sharing to see a Non-Participating Provider as compared to a Participating Provider. However, the following Covered Services, when rendered by a Non-Participating Provider, will be Covered at the Participating Provider benefit level when the Non-Participating Provider renders services in a Participating Provider Facility or a Participating Provider submits a specimen to a Non-Participating Provider laboratory:

(1) Advanced imaging services (i.e. PET scan, MRI, nuclear medicine and CAT scans);
(2) Anesthesia services; and
(3) Diagnostic and routine x-ray, laboratory and pathology services.

Note: The exception listed above for Non-Participating Providers is only applicable to medical benefits Covered under the Plan.

Non-Preferred Drug. Any Brand Name Drugs that do not appear on the list of Preferred Drugs.

Out-of-Pocket Limit. The most you pay during a Plan Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This limit never includes Balance Billing charges, Preauthorization penalty amounts (if any) or the cost of health care services not Covered under the terms and conditions of the Plan.

Participating Pharmacy. A pharmacy that has:
(1) Entered into an agreement with the Prescription Drug Benefit Manager or its designee to provide Covered Prescription Drugs to Covered Persons;
(2) Agreed to accept specified reimbursement rates for dispensing Covered Prescription Drugs; and
(3) Been designated by the Prescription Drug Benefit Manager or its designee as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

Participating Provider. A Facility, Health Care Professional, or Provider of Additional Health Services who has a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide services to you at a discounted rate. Participating Providers have agreed to accept the discounted rate as payment in full for services Covered under the Plan. A list of Participating Providers and their locations is available

at www.excellusbcbs.com or upon request by calling the customer service number located on your identification card. The list may be revised from time to time.

Preferred Drug. A list of Brand Name Drugs that have been developed by the Pharmacy and Therapeutics Committee that is comprised of Physicians, pharmacists and other Health Care Professionals; or has been identified by the Prescription Drug Benefit Manager as a Preferred Drug, based on available data resources. All Prescription Drugs identified as "preferred" by the manufacturer, pharmacy, or your Physician may not be classified as a Preferred Drug by the Plan.

Physician or Physician Services. Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan. Syracuse City School District Health Benefits Plan.

Plan Administrator. The Plan Administrator is the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Sponsor. Syracuse City School District or any successor thereto.

Plan Year. The 12-month period beginning on July 1 and ending on June 30.

Preauthorization. A decision by the Plan prior to your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. Covered Services that require Preauthorization are listed in the Medically Necessary and Preauthorization section of this Plan.

Prescription Drugs. A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on the Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Drug Benefit Manager. CVS Caremark- www.Caremark.com- customer care phone number: 1-888-626-1083.

Prescription Drug Cost. The amount, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy.

Prescription Order or Refill. The directive to dispense a Covered Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

Primary Care Physician ("PCP"). A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for you.

Provider of Additional Health Services. A provider of services or supplies Covered under this Plan (such as diabetic equipment and supplies, prosthetic devices or Durable Medical Equipment) that is not a Facility or Health Care Professional, and that is licensed or certified according to applicable state law or regulation; approved by the applicable accreditation body, if any; and/or recognized for payment under this Plan.

Qualified Clinical Trial. A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(1) The National Institutes of Health;

(2) The Centers for Disease Control and Prevention;

(3) The Agency for Health Research and Quality;

(4) The Centers for Medicare & Medicaid Services;

(5) A cooperative group or center of any of the entities described in (1) through (4) above or the Department of Defense or the Department of Veterans Affairs;

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(7) The Department of Veterans Affairs, Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Rehabilitation Services. Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Retiree. A former Employee of the Employer that satisfies the Retiree eligibility requirements of the Plan.

Schedule of Benefits. The section of this Plan that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, and other limits on Covered Services.

Service Area. The geographical area in which the Claims Administrator provides benefits to a Covered Person. The Service Area consists of: Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware;

Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson counties.

Skilled Nursing Facility. An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by the Plan to meet the standards of any of these authorities.

Specialist. A Physician who focuses on a specific area of medicine or on a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse. A person who is legally married to an Employee (provided marriage is recognized as such for purposes of federal tax laws). A Spouse does not include someone that is legally separated or divorced from the Employee.

Substance Use Disorder. A Substance Use Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

UCR (**Usual, Customary and Reasonable).** The cost of a medical service in a geographic area based on what a Facility, Health Care Professional, or a Provider of Additional Health Services in the area usually charges for the same or similar medical service.

Urgent Care. Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center. A licensed Facility that provides Urgent Care.

Usual and Customary Charge. The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

You, Your and Yours. Throughout this Plan, the words “you”, “your” and “yours” refers to you, the Covered eligible Employee and your Covered eligible Dependents.

ELIGIBILITY

Employee Eligibility

An Employee is eligible for coverage under the Plan in accordance with the eligibility rules established by the Employer. Eligibility rules can vary subject to union negotiated settlements or policy changes by your Employer. To be eligible for Plan enrollment, Employees must have been hired for an anticipated full-time employment period of at least three (3) months. Other requirements for eligibility are based on your bargaining unit's contract with your Employer. In addition, even though Employee eligibility requirement may be met, any unenrolled Employee who submits an initial enrollment application while temporarily removed from 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 Employer's payroll.

Coverage under the Plan will take effect for an eligible Employee when the Employee satisfies all eligibility requirements of the Plan. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all.

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

Please contact your Employer if you have questions with respect to your eligibility for benefits under the Plan.

You are not eligible to participate in the Plan if you are classified as a part-time, temporary, leased or a seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law Employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Dependent Eligibility

Your Dependents are eligible for coverage under the Plan, provided he/she is:

(1) Your Spouse.

(2) Your Child until the end of the month of the Child's 26th birthday.

(3) Your unmarried Child age 26 or older, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap and who became so incapable prior to the end of the month in which the Child attained age 26. Your Child must have been Covered under the Plan prior to the end of the month in which the Child attains age 26, be chiefly dependent upon you for support and maintenance and must reside with you for more than one-half of the Calendar Year.

You have 30 days from the end of the month in which your Child attains age 26 to provide proof of the Child's incapacity and to request continued coverage for such Child under this Plan. The Plan Sponsor may request subsequent proof of your Child's incapacity and eligibility for coverage under the Plan pursuant to this provision.

Retiree Eligibility

A Retiree is eligible for coverage under the Plan in accordance with the eligibility rules established by the Employer. Listed below are general eligibility requirements for Retiree coverage under the Plan. For complete details, please contact your Employer.

An Employee, who retirees on or after attaining age 55, will be eligible for full participation in the Plan as a Retiree if the following conditions are satisfied:

(1) He/she is hired prior to January 1, 1980 with at least 5 years of service, 10 years of service (if part of bargaining units 02, 06, 07, 08, and 09) or 15 years of service (if part of bargaining units 03, 05, 11, and 12) at the time of retirement;
(2) He/she is hired prior to September 28, 2007 with at least 10 years of service (if part of bargaining units 01 and 10);
(3) He/she is hired on or after September 28, 2007 with at least 15 years of service (if part of bargaining units 01 and 10).
(4) A Retiree may not change benefits from single to family after the date of retirement; however, they may change from family to single coverage.
(5) A person under the age of 55, who receives disability retirement benefits, has the same rights as a regular Retiree.
(6) 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 Board of Education has the same rights as a regular Retiree.
(7) If a Retiree has acquired, or in the future becomes eligible to acquire, health benefits from another employer, the Retiree ***mus*t** enroll either as a dependent or an employee in the other employer's plan.

In addition to the above, an Employee with New York State vested rights (at least 10 years of service) who leaves the Employer between ages 50 and 55 can remain in the Plan if they pay 100% of the cost. If the person leaves the Plan at any time during this period, they cannot be reinstated. If the person remains in the Plan until age 55, they are then continued in the Plan under the same conditions as someone who retires on or after reaching age 55.

You may be required to pay for the full or partial cost of Retiree coverage, please refer to the most recent contract with your applicable bargaining unit.

Timely Enrollment

Once you are eligible to participate in the Plan, you must enroll in coverage under the Plan within 30 days after you satisfy the eligibility requirements. Any required election or enrollment form must be submitted to your Human Resources Department no later than the 30-day period described above. The initial election/enrollment form includes a payroll deduction authorization that permits your Employer to deduct the required

contributions (if any)from your pay.

If you decline enrollment for you and/or your Dependents because you have other health coverage, you must provide a written notice to your Human Resources Department indicating the reason you are declining coverage. If you lose such other coverage it may constitute a special enrollment or a change in status event that gives you and/or your Dependents the right to enroll in the Plan mid-year. If you failed to submit such written statement, you will not be eligible to enroll mid-year and will be required to wait until the next annual enrollment period.

Annual Enrollment Period
This Plan has an annual enrollment period. The annual enrollment period is the period of time prior to the start of the Plan Year where an eligible Employee and/or eligible Dependent can elect coverage under the Plan or can change coverage under the Plan. The annual enrollment period under the Plan will be communicated to you each year by your Human Resources Department.

If you fail to complete and submit the required election and enrollment forms within the annual enrollment period, you will not be eligible to enroll in the Plan until the next annual enrollment period, unless you experience an earlier special enrollment or a change in status event (as described below).

Special Enrollment Event
You may make a mid-year change in your election as a result of any of the following special enrollment events:

(1) **Loss of Other Coverage.** You previously declined coverage for yourself and/or your eligible Dependents because you and/or your Dependents had other health coverage and you submitted a written statement to your Human Resources Department when you were initially eligible declining enrollment under the Plan because of such other health coverage, but that other health coverage was lost as a result of one of the following events:

(a) Legal separation, divorce, death, loss of Dependent status, termination of employment, reduction in hours, or any other reason required by HIPAA;

(b) The other health coverage was COBRA and the maximum continuation period available under COBRA has been exhausted; or

(c) Employer contributions for the other health coverage ended.

If you and/or your Dependent lost the other health coverage for reasons of non-payment of the required contribution or premium, making a fraudulent claim or an intentional misrepresentation of material fact, then you and/or your Dependents will not be eligible to take advantage of this special enrollment right and enroll in the Plan mid-year.

If you are the one that loses the other health coverage, you may enroll yourself and any eligible Dependents in the Plan. If your eligible Dependent loses the

other health coverage, and you are already enrolled in the Plan, you may enroll your Dependent in that same benefit option you are already enrolled in or you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must request enrollment in the Plan by submitting any required enrollment and election forms to your Human Resources Department no later than 30-days after the date your other health coverage was lost. Coverage under the Plan will begin as of the date coverage was lost. Failure to enroll in the Plan will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual enrollment period, or in the event you experience another special enrollment or change in status event.

(2) **Acquisition of a New Dependent.** You declined to enroll, failed to enroll or enrolled in Employee-only coverage under the Plan when you were initially eligible or during the Plan's annual enrollment period and you acquire a new Dependent mid-year as a result of marriage, birth, adoption or placement for adoption.

You must request enrollment in the Plan by submitting any required enrollment and election forms to your Human Resources Department no later than 30-days after the date of the event. Coverage under the Plan will begin as follows:

(a) For a newborn Child (other than a proposed adopted newborn Child), coverage will begin as of the date of birth, provided you request enrollment within the 30-day period described above.

(b) For a proposed adopted newborn Child, coverage will begin as of the date of birth, provided you request enrollment within the 30-day period described above; and

(i) You take physical custody of the newborn as soon as he/she is released from the Hospital after birth; and
(ii) File a petition for adoption within 30 days after the Child's birth.

Coverage under the Plan will not be provided for the proposed adopted newborn Child if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If the Plan provides coverage of a proposed adopted newborn Child, and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Plan will be entitled to recover any sums paid by it for care of the proposed adopted newborn Child.

(c) For an adopted Child (or Child placed with you in anticipation of adoption), coverage will begin as of the date of adoption (or placement for adoption), provided you request enrollment within the 30-day period described above.

(d) For a newly acquired Dependent as a result of marriage, coverage will begin as of the date of marriage, provided you request enrollment within the 30-day period described above.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan, other than the first 30-days after birth for a newborn Child or a proposed adopted newborn Child. You may elect to enroll in the Plan again during the Plan's next annual enrollment period, or in the event you experience another special enrollment or change in status event.

(3) **Eligibility Changes in Medicaid and State Child Health Insurance Programs (SCHIP).** You declined or failed to enroll in coverage under the Plan when you were initially eligible because:

(a) you were covered under Medicaid or a SCHIP at the time you were initially eligible, but now your coverage under Medicaid or a SCHIP has terminated due to loss of eligibility for such coverage; or

(b) You became eligible for a state premium assistance subsidy under Medicaid or SCHIP to assist with payment of any required Employee contribution under the Plan.

Coverage under the Plan will begin as of the date you request enrollment in the Plan, provided such request is made within 60-days after coverage under Medicaid or SCHIP terminates or you become eligible for a state premium assistance subsidy. Additional information regarding premium assistance under Medicaid or SCHIP is attached to this SPD as Exhibit A.

Failure to enroll in the Plan within the 60-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual enrollment period, or in the event you experience another special enrollment or change in status event.

Change in Status Event

Your election under the Plan will remain in effect for the entire Plan Year, unless you experience a special enrollment event (described above) or a change in status event, as defined under Section 125 of the Internal Revenue Code (including any applicable regulations). Any new election made under the Plan due to a change in status event must be consistent with such event. Change in status events include:

(1) A change in your marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;

(2) A Dependent loses or gains eligibility under the Plan, such as attainment of a specified age; birth, adoption or placement for adoption of a Dependent; death of a Dependent; or a change in the Plan's Dependent eligibility requirements;

(3) Change in employment status that causes you, your Spouse or Dependent Child to either gain or lose eligibility under the Plan, including commencement or termination of employment; commencement or return from a leave of absence; or any other employment status change that affects the eligibility status of an individual to participate in the Plan, including a change from part-time to full-time

status or vice versa, a change from salaried to hourly or vice versa, or a strike or lockout;

(4) Gain or loss of eligibility under the Plan or another employer-sponsored welfare benefit plan;

(5) Significant increase or decrease in the cost of coverage under the Plan, including a new benefit option being added, a benefit option being eliminated or significantly curtailed and a coverage change made under a plan offered by the employer;

(6) Change in your residence or the residence of your Dependent that is outside the Plan's Service Area;

(7) Change in election under another employer-sponsored welfare benefit Plan during an open enrollment period under another employer-sponsored welfare benefit Plan that differs from the annual enrollment period under this Plan;

(8) You or your Dependent become covered or lose coverage under Medicare or Medicaid.

Depending on the change in status event, you may be permitted to revoke your existing election or make a new election under the Plan, provided it is consistent with the event and satisfies the regulations under Internal Revenue Code Section 125. For additional information regarding whether or not something constitutes a change in status event, please contact your Human Resources Department.

Coverage under the Plan will begin as of the date of the change in status event, provided you request enrollment and submit any required election and enrollment forms no later than 30 days after the event.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual enrollment period, or in the event you experience another special enrollment or change in status event.

Change in Election Due to Marketplace Coverage

If you have an opportunity to enroll in a qualified health plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), you may change your benefit elections under this Plan to cancel medical coverage under this Plan but only if you (and all Dependents whose coverage under this Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under this Plan based on this rule will be permitted only if the Marketplace Coverage (for all Covered Persons whose coverage under this Plan is being cancelled) is effective no later than the next day after coverage under this Plan would terminate because of the cancellation of coverage. The Plan may rely on your reasonable representation that all Covered Persons whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Also, note that you are permitted to enroll

in Marketplace Coverage only during the annual Marketplace enrollment period or based on a marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: https://nystateofhealth.ny.gov/.

WHEN COVERAGE ENDS

Employee Coverage Ends: Your coverage under the Plan ends on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The last day of the period for which the required contribution has been paid;

(3) For ten (10) month Employees, whose employment with the Employer terminates after June 30th or who fail to report to work in September, coverage will end on September 1st;

(4) The 1st or 16th day of the next month following the date of the last payroll period in which contributions for coverage were made. If you are retiring, you may be eligible for retiree coverage. Please see the Retiree Eligibility section of the Plan for further details.

(5) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);

(6) The 1st or 16th day of the next month following the date you change to an Employee classification that is not benefits-eligible;

(7) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or

(8) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

Dependent Coverage Ends: Dependent coverage will end on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Employee's eligibility or coverage under the Plan terminates;

(3) The end of the month the Dependent Child, or for all other Dependents the date the Dependent, no longer qualifies as a Dependent under the Plan;

(4) The last day of the period for which the required contribution has been paid;

(5) The date Dependent coverage under the Plan is terminated;

(6) The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice or omission that constitutes fraud; or

(7) The date the Dependent (or any person seeking coverage on behalf of the

Dependent) makes an intentional misrepresentation of material fact.

Retiree Coverage Ends: Retiree coverage for both the Retiree and any eligible Dependents ends on the earliest of the following dates:

(1) The date the Plan is terminated, in whole or in part;

(2) The date the Plan no longer provides Retiree coverage;

(3) The last day of the period for which the required contribution has been paid;

(4) The date the Retiree no longer meets the eligibility requirements for Retiree coverage under the Plan;

(5) The date in which a Dependent no longer qualifies as a Dependent;

(6) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) performs an act, practice or omission that constitutes fraud; or

(7) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) makes and intentional misrepresentation of material fact.

Rescission of Coverage
Coverage under this Plan may be retroactively canceled or terminated if you or your Covered Dependents (or a person seeking coverage on behalf of you and/or your Covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or the person makes an intentional misrepresentation of material fact. In such cases, the individuals coverage that is being canceled or terminated will be provided with 30 days advance written notice before such cancelation or termination. Notwithstanding the above, coverage may be retroactively terminated in cases where required contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Coverage due to Total Disability or Approved Leave of Absence.
If you are covered under the Plan and suffer from Total Disability, Plan coverage for you and your eligible Dependents will continue for up to one (1) year following the date your Total Disability begins.

If you are covered under the Plan and begin an approved leave of absence, Plan coverage for you and your eligible Dependents may continue in accordance with the agreement between you and your Employer.

For purpose of this section, Total Disability means being completely unable , as a result of sickness or injury, to do the substantial and materials 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, for the Dependent,

means 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.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of active Employees. If a COBRA qualifying event occurs, any period of continued coverage under this section will reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the Continuation of Coverage section of this Plan.

SURVIVOR BENEFIT

If you are an eligible Retiree your surviving Spouse who is covered under the Plan at the time of your death will be eligible to continue coverage under the Plan after your death if your surviving Spouse elects to continue coverage under the Plan within two (2) months after the date of your death. If your surviving Spouse fails to make election under the Plan within this two (2) month period of time, he/she will not eligible for continued coverage under this survivor benefit. Your surviving Spouse must make any required contribution, if any, toward the cost of coverage. The cost of coverage, if any, under this survivor benefit will be communicated to your survivor(s) by the Plan Administrator.

Coverage under the Plan will terminate for a surviving Spouse on the earliest of the following:

(1) The date the Plan is terminated, in whole or in part;

(2) The last day of the period for which the required contribution has been paid;

(3) The surviving Spouse's date of death;

(4) The date the surviving Spouse remarries;

(5) The date this survivor benefit is no longer offered under the terms of the Plan;

(6) The date the any surviving Spouse (or any person seeking coverage on behalf of the surviving Spouse) performs an act, practice or omission that constitutes fraud; or

(7) The date the surviving Spouse (or any person seeking coverage on behalf of the surviving Spouse) makes an intentional misrepresentation of material fact.

COBRA not available when survivor benefit ends. At the time of your death, your surviving Spouse may elect COBRA in lieu of Plan coverage under this survivor benefit. If your surviving Spouse elects COBRA in lieu of Plan coverage, they will not be eligible to enroll in the Plan at a later time. If however, if they elect to continue Plan coverage under this survivor benefit in lieu of COBRA, the coverage available under this survivor benefit will be treated as alternative coverage and they will be waiving their rights to continue coverage under COBRA and will not be eligible to continue coverage under COBRA once Plan coverage available under this survivor benefit ends.

MEDICAL NECESSITY AND PREAUTHORIZATION

(1) **Care Must Be Medically Necessary.** Coverage will be provided under the Plan for the Covered Hospitalization, care, service, technology, test, treatment, drug or supply (collectively, "Service(s)") described in this Plan, as long as the Service is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the coverage has to be provided for the Service under the Plan.

The Plan will decide whether a service was Medically Necessary. The Plan will base its decision, in part, on a review of your medical records. The Plan will also evaluate medical opinions it receives. This could include the medical opinion of a professional society, peer review committee or other groups of physicians.
In determining if a service is Medically Necessary, the Plan will also consider:

(a) Reports in peer reviewed medical literature;

(b) Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

(c) Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;

(d) The opinion of health professionals in the generally recognized health specialty involved;

(e) The opinion of the attending Health Care Professional, which have credence but do not overrule contrary opinions; and

(f) Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

(a) They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;

(b) They are required for the direct care and treatment or management of that condition;

(c) If not provided, your condition would be adversely affected;

(d) They are provided in accordance with generally-accepted standards of medical practice;

(e) They are not primarily for the convenience of you, your family, the Health Care Professional or another provider;

(f) They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to

the diagnosis or treatment of your illness, injury or disease; and

(g) When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

(2) **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless the Plan determines that the Service is: consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative for the Service described and Covered under this Plan, as long as the Service is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the coverage has to be provided for the Service under the Plan.

(3) **Services subject to Preauthorization.** If Services are rendered by a Participating Provider, your provider is required to obtain Preauthorization for certain services Covered under this Plan. If Services are rendered by a Non-Participating Provider, you are required to obtain Preauthorization for certain services Covered under this Plan. A list of Services that require Preauthorization can be obtained by visiting www.excellusbcbs.com. This list is subject to change and is updated from time to time. To verify whether or not a specific Service requires Preauthorization, or to request a paper copy (free of charge) of the list of Services that require Preauthorization, please contact the customer service number listed on your ID card.

(4) **Preauthorization Procedure.** If you seek coverage for the Services listed in paragraph 3 above, your provider must call the Claims Administrator at the number indicated on your ID card to have the care pre-approved. It is requested that your provider call at least seven days prior to a planned inpatient admission.

If you are hospitalized in cases of an Emergency Condition involving any of these services, you should call within 24 hours after your admission or as soon thereafter as reasonably possible. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph.

After receiving a request for Preauthorization, the Claims Administrator will review the reasons for your planned treatment and determine if benefits are available. The Claims Administrator will notify you and your Health Care Professional of the decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, the Claims Administrator will notify you and your Health Care Professional within one business day of receipt of all necessary information.

(5) **Your Right to Appeal.** If you or your Health Care Professional disagrees with the

Claims Administrator's decision, you may appeal by following the procedures set forth in the Claim Procedures section of this Plan.

(6) **Failure to Seek Preauthorization.** If your Participating Provider fails to seek Preauthorization for the Services described in paragraph (3) above, other than with respect to any Services received due to an Emergency Condition, the Plan will not provide any coverage for those services; however, you will be held harmless and not subject to any penalties. If you fail to seek Preauthorization for Services rendered by a Non-Participating Provider, no penalty will apply. The Plan will pay the amount specified above only if it is determined that the Services were Medically Necessary. If it is determined that Services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

INPATIENT CARE

(1) **In a Facility**. If you are a registered bed patient in a Facility, benefits will be provided under the Plan for most of the services provided by the Facility, subject to the conditions and limitations below and in the Schedule of Benefits. The services must be Medically Necessary; the services must be given to you by an Employee of the Facility; the Facility must bill for the services; and the Facility must retain the money collected for the services.

(2) **Services not Covered.** The Plan will not provide coverage for:

(A) Additional charges for special duty nurses;

(B) Private room, unless it is Medically Necessary for you to occupy a private room or the Facility has no semi-private rooms. If you occupy a private room in a Facility, and it is determined that a private room is not Medically Necessary and that the Facility has semi-private rooms, the Plan's coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;

(C) Non-medical items, such as telephone or television rental;

(D) Medications, supplies and equipment that you take home from the Facility; or

(E) Custodial care.

(3) **Conditions for Inpatient Care.** Inpatient Facility care is subject to the following conditions:

(A) **Inpatient Hospital Care.** The Plan will provide coverage when you are required to stay in a Hospital for Acute medical or surgical care. The Plan will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care.

(B) **Mental Health Inpatient Services.** The Plan provides coverage for inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders comparable to other similar Hospital, medical and surgical coverage provided under this Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

I. A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
II. A state or local government run psychiatric inpatient Facility;
III. A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;

IV. A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

The Plan also Covers inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Plan, and that provide (at a minimum) those services and treatments identified in the most recent McKesson InterQual criteria for a psychiatric residential treatment center or in such other comparable criteria recognized by the Plan.

(C) **Substance Use Inpatient Services.** The Plan Covers inpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders. This includes coverage for detoxification and Rehabilitation Services as a consequence of a Substance Use Disorder. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also Covers inpatient substance use services relating to the diagnosis and treatment of a Substance Use Disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

(D) **Skilled Nursing Facility.** The Plan will provide coverage for care in a Skilled Nursing Facility if it is determined that Hospitalization would

otherwise be Medically Necessary for the care of your condition, illness or injury.

(E) **Physical Rehabilitation.** The Plan will provide coverage for comprehensive physical medicine and rehabilitation for a condition that in the judgment of your Health Care Professional and the Plan can reasonably be expected to result in significant improvement in a relatively short period of time.

(4) **Maternity Care and Newborn Care.** The Plan will provide coverage for inpatient maternity care in a Hospital for any Covered Person, and inpatient newborn care in a Hospital for the infant, if Covered under the Plan, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan will also provide coverage for any additional days of such care that are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, the Plan will provide coverage of the home care furnished by the type of home care agency described in the Home Care section of this Plan. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. The Plan's coverage of this home care visit shall not be subject to any Cost-Sharing amounts payment amounts described in the Home Care section of this Plan.

(5) **Mastectomy Care.** The Plan's coverage of inpatient Hospital care includes coverage of an inpatient Hospital stay following a lymph node dissection, lumpectomy, or mastectomy or partial mastectomy for the treatment of breast cancer. The length of stay will be determined by you and your Health Care Professional. The Plan will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

(6) **Internal Prosthetic Devices.** The Plans coverage for inpatient Hospital care includes coverage for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include: cardiac pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.

(7) **Observation Stay.** The Plan will provide coverage for observation services for up to 48 hours. Observation services are: furnished in the outpatient department of a Facility; and are in lieu of an inpatient admission. The services include: use of a bed; and periodic monitoring by nursing or other licensed staff that is reasonable and necessary to evaluate the patient's condition or determine the need for an inpatient admission.

OUTPATIENT CARE

The Plan will provide coverage for the same services it would Cover if you were an inpatient in connection with the care described below when given to you in the outpatient department of a Facility. As in the case of inpatient care, the service must be Medically Necessary; the service must be given by an Employee of the Facility; the Facility must bill for the service; and the Facility must retain the money collected for the service.

(1) **Care in Connection with Surgery.** The Plan will only provide coverage if it was Medically Necessary to use the Facility to perform the surgery.

(2) **Pre-Admission Testing.** The Plan will provide coverage for tests ordered by a Health Care Professional which are given to you as preliminary to your admission to the Facility as a registered bed patient for surgery if all of the following conditions are met:

(A) They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

(B) A reservation has been made for the Facility bed and/or the operating room before the tests are given; and

(C) You are physically present at the Facility when these tests are given.

(3) **Diagnostic Imaging Procedures.** The Plan will provide coverage for diagnostic imaging procedures, including x-rays, ultrasound, computerized axial tomography ("CAT") and positron emission tomography ("PET") scans, and magnetic resonance imaging ("MRI") procedures.

(4) **Laboratory and Pathology Services.** The Plan provides coverage for routine laboratory procedures and diagnostic testing, services and materials, including electroencephalograms and laboratory tests.

(5) **Radiation Therapy.** The Plan will provide coverage for radiation therapy in an outpatient Facility or in a Health Care Professional's office.

(6) **Chemotherapy.** The Plan will provide coverage for chemotherapy in an outpatient Facility or in a Health Care Professional's office.

(7) **Dialysis.** The Plan will provide coverage for dialysis treatments of an Acute or chronic kidney ailment.

(8) **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Plan covers mammograms (including 3D mammograms) for the screening of breast cancer annually for Covered Persons age 35 and over.

If a Covered Person of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Plan covers mammograms as

recommended by the Covered Person's provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Diagnostic mammograms (mammograms that are performed in connection with the diagnosis of breast cancer) are Covered whenever they are Medically Necessary.

The Plan also Covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

(9) **Cervical Cytology Screenings (Pap Smears).** The Plan will provide coverage for screening for cervical cancer and its precursor states for Covered Persons 18 years of age or older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines, when provided in the outpatient department of a Facility under this section or in a Health Care Professional's office under the Professional Services section of the Plan. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(10) **Colonoscopy.** The Plan provides coverage for colonoscopies to screen for colon cancer in an asymptomatic Covered Person in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from the USPSTF.

Diagnostic colonoscopies (colonoscopies that are performed in connection with the treatment or follow-up of colon cancer) are Covered whenever they are Medically Necessary.

(11) **Mental Health Disorder Outpatient Services.** The Plan Covers outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes only Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a psychiatric nurse, licensed as a nurse practitioner; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof.

(12) **Substance Use Outpatient Services.** The Plan Covers outpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders, , including but not limited to partial Hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling and medication-assisted treatment. Such coverage is limited to Facilities in New York State that are certified or otherwise authorized by OASAS to provide outpatient Substance Use Disorder services, and, in other

states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a Substance Use Disorder provided by an OASAS credentialed provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also Covers outpatient visits for family counseling. A family member will be deemed to be Covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from alcoholism, substance use and dependency; and 2) and the person receiving, or in need of, treatment for alcoholism, substance use and dependency are both Covered under this Plan. The payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

(13) **Covered Therapies.** The Plan will provide coverage for physical, occupational, and speech therapy (both rehabilitation and habilitation) when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist, or by another Facility employee who is licensed to provide such services, and when it is determined that your condition is subject to significant clinical improvement through relatively short-term therapy.

(14) **Pulmonary Rehabilitation.** The Plan will provide coverage for patient assessment and formal training and education phases of pulmonary rehabilitation programs. Services must be rendered by an approved pulmonary rehabilitation program provider and recommended by the Covered Person's cardiologist or Health Care Professional.

(15) **Cardiac Rehabilitation.** The Plan will provide coverage for Phase I and Phase II cardiac rehabilitation programs. Services must be rendered by an approved cardiac rehabilitation program provider and recommended by the Covered Person's cardiologist or Health Care Professional.

(16) **Infertility Services.** The Plan will provide coverage for outpatient Facility care in connection with the diagnosis of infertility provided by a Health Care Professional pursuant to the Professional Services section of the Plan.

You are responsible for any applicable Deductible, Copayment or Coinsurance provisions under this section for similar services.

HOME CARE

(1) **Type of Home Care Provider.** The Plan will provide coverage for home care visits given by a certified home health agency or licensed home care services agency if your Health Care Professional and the Plan determine that the visits are Medically Necessary.

If operating outside of New York State, the Home Health Agency or home care services agency must be qualified by Medicare.

(2) **Eligibility for Home Care.** The Plan will provide coverage for home care only if all the following conditions are met:

(A) A treatment plan is established and approved in writing by your Health Care Professional;

(B) You apply to the home care provider through your Health Care Professional with supporting evidence of your need and eligibility for the care; and

(C) The home care is related to an illness or injury for which you were hospitalized or for which you would have been hospitalized or confined in a nursing Facility. The care must be Medically Necessary at a skilled or Acute level of care.

You will not be entitled to coverage of any home care after the date it is determined that you no longer need such services.

(3) **Home Care Services Covered.** Home care will consist of one or more of the following:

(A) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;

(B) Part-time or intermittent home health aide services, that consist primarily of direct care rendered to you;

(C) Physical, occupational or speech therapy provided by the Home Health Agency or home care services agency; and

(D) Medical supplies, drugs and medications prescribed by your physician, laboratory services, Durable Medical Equipment and infusion therapy, when provided by or on behalf of the Home Health Agency or home care services agency, but only to the extent such items would have been Covered under the Plan if you were an inpatient in a Hospital or Skilled Nursing Facility.

(4) **Failure to Comply with Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, the Plan will terminate benefits for that plan of care.

HOSPICE CARE

(1) **Eligibility for Benefits.** In order to receive these benefits, which are non-aggressive services provided to maintain the comfort, quality and dignity of life to the terminally ill patient, you must meet the following conditions:

(A) The attending physician estimates your life expectancy to be six (6) months or less.

(B) Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

(2) **Hospice Organizations.** In New York State, the Plan will provide coverage only for Hospice Care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the Hospice Care is provided outside of New York State, the hospice organization must have an operating certificate issued 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 approved by Medicare.

(3) **Hospice Care Benefits.** The Plan will provide coverage for the following services when provided by a hospice:

(A) Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular Hospital bed;

(B) Day care services provided by the hospice organization;

(C) Home care and outpatient services which are provided and billed through the hospice. The services may include at least the following:

I. Intermittent nursing care by an R.N., L.P.N. or home health aide;

II. Physical therapy;

III. Speech therapy;

IV. Occupational therapy;

V. Respiratory therapy;

VI. Social services;

VII. Nutritional services;

VIII. Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;

IX. Medical supplies;

X. Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. The Plan will not provide coverage when the drug or medication is of an experimental nature;

XI. Durable Medical Equipment; and

XII. Bereavement services provided to the terminally ill patient's family during illness, and until one (1) year after death.re

(D) Medical care provided by a Physician.

PROFESSIONAL SERVICES

The Plan will provide coverage for the services of Health Care Professionals described below.

(1) **Surgery.** Surgery includes operative procedures for the treatment of disease or injury and elective termination of pregnancy and elective sterilization. It includes any pre and post-operative care usually rendered in connection with such procedures. Pre-operative care includes pre-operative examinations that result in a decision to operate. Surgery also includes endoscopic procedures and the care of fractures and dislocations of bones.

The Plan will also provide coverage for surgical services including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. The Plan will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Health Care Professional.

(A) **Inpatient Surgery.** The Plan will provide coverage for surgical procedures performed while you are an inpatient in a Hospital or other Facility.

(B) **Outpatient Surgery.** The Plan will provide coverage for surgical procedures performed in the outpatient department of a Hospital or other Facility or in a Hospital-based or freestanding ambulatory surgery Facility.

(C) **Office Surgery.** The Plan will provide coverage for surgical procedures performed in the Health Care Professional's office.

(D) **Multiple Surgical Procedure Rules.** If multiple surgical procedures are performed during the same operative session, the following rules apply. In these rules, the term "primary procedure" means the most expensive procedure, i.e., the procedure with the highest Allowed Amount. The term "secondary procedure" means any procedure other than the primary procedure.

A laparoscopic procedure with multiple entry points is considered to be a single incision for purposes of applying these rules.

I. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, this Plan will provide the benefits described above for the primary procedure. The Plan will pay 50% of the amount otherwise payable hereunder for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions.

The Plan will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to

the primary procedure. Examples of incidental procedures are: an appendectomy; lysis of adhesions; splenectomy without separate pathology; biopsies of lymph nodes, liver, omentum or other organs; hernia through the same incision (umbilical, ventral, internal inguinal); secondary organs and en bloc incisions; tube enterostomies for decompression; and vasectomy accompanying prostatectomy.

II. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, The Plan will provide the following benefits:

i. The benefit described above for the primary procedure; plus
ii. 50% of the amount otherwise payable for all other procedures.

(2) **Covered Therapies.** The Plan will provide coverage for physical, occupational, and speech therapy (both rehabilitation and habilitation) when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist, or by another Facility employee who is licensed to provide such services, and when it is determined that your condition is subject to significant clinical improvement through relatively short-term therapy.

(3) **Anesthesia Services.** This includes the administration of necessary anesthesia and related procedures in connection with a Covered surgical service. The administration and related procedures must be done by a Health Care Professional other than the Health Care Professional performing the surgery or an assistant. The Plan will not provide coverage for the administration of anesthesia for a procedure not Covered by this Plan.

(4) **Additional Surgical Opinions.** The Plan will provide coverage for a second opinion, or a third opinion if the first two opinions do not agree, with respect to proposed surgery subject to all the following conditions:

(A) You seek the second or third surgical opinion after your surgeon determines your need for surgery.

(B) The second or third surgical opinion is rendered by a physician:

I. Who is a board certified specialist; and
II. Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure.

(C) The second or third surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under the Plan if such surgery was performed.

(D) You are examined in person by the physician rendering the second or third surgical opinion.

(E) The specialist who renders the opinion does not also perform the surgery.

(5) **Second Medical Opinions.** The Plan will provide coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Health Care Professional as having some form of cancer. A negative diagnosis of cancer occurs when your Health Care Professional performs a cancer-screening exam on you and finds that you do not have cancer, based on the exam results. The Plan will also provide coverage for a second medical opinion concerning any recommendation of a course of treatment of cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to, a specialist associated with a specialty care center for the treatment of cancer.

(6) **Maternity Care.** The Plan will provide coverage for:

(A) **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, practicing consistent with the requirements of Section 6951 of the New York Education Law, and affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law or comparable law of another state.

(B) **Complications of Pregnancy and Termination.** The Plan will provide coverage for complications of pregnancy and for Medically Necessary terminations of pregnancy.

(C) **Anesthesia.** The Plan will provide coverage for delivery anesthesia.

(7) **Inpatient Medical Services.** The Plan will provide coverage for medical visits by a Health Care Professional on any day of inpatient care Covered under the Inpatient Care section of this Plan. The Plan will not provide coverage for medical visits by Facility employees or interns, even if they are Health Care Professionals.

The Health Care Professional’s services must be documented in the Facility records. The Plan will Cover only one visit per day per Health Care Professional. However, services rendered by up to two Health Care Professionals on a single day will be Covered if the two Health Care Professionals have different specialties and are treating separate conditions.

(8) **Medical Care in a Health Care Professional's Office.** Unless otherwise provided below, the following services are Covered in a Health Care Professional’s office:

(A) **Preventive Health Services.** The Plan will provide coverage for the following health prevention programs rendered in the Health Care Professional's office or by other providers designated by the Medical Director:

I. **Routine Physical Examinations.** The Plan will provide coverage for adult routine physical examinations in accordance with a schedule based on national coverage determinations, but not to exceed one examination per Covered Person per Plan Year.

II. **Well Child Visits and Immunizations.** The Plan will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics. The Plan will also Cover childhood immunizations recommended by the Advisory Committee on Immunization Practices ("ACIP"), in accordance with the ACIP recommended schedule.
The Plan will Cover services typically provided in conjunction with a well child visit. Such services include at least: complete medical histories; a complete physical exam; developmental assessments; anticipatory guidance; laboratory tests performed in the practitioner's office or in a clinical laboratory; and/or other services ordered at the time of the well child visit.

III. **Adult Immunizations.** The Plan will provide coverage for adult immunizations according to ACIP recommendations. The Plan will provide coverage for flu mist according to the Excellus BlueCross BlueShield medical policy.

(B) **Other Health Services.**

I. **Laboratory and Pathology Services.** The Plan provides coverage for routine laboratory procedures and diagnostic testing, services and materials, including electroencephalograms and laboratory tests.

II. **Vision Examinations.** The Plan will provide coverage for diagnostic vision examinations.

III. **Hearing Examinations.** The Plan will provide coverage for diagnostic hearing examinations and evaluations.

(C) **Diagnostic and/or Treatment Office Visits.** The Plan will provide coverage for office visits to diagnose and/or treat illness or injury.

(D) **Office Consultations.** The Plan will provide coverage for consultations billed by a physician. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

(9) **Telehealth/Telemedicine.** The Plan will provide coverage for any services delivered by a provider using telehealth/telemedicine ("Telehealth"). Covered services delivered using Telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Plan that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information

and communication technologies (e.g. telephone consultations, e-mail consultations, online internet consultations, etc.) by a provider to deliver covered services to a Covered Person while that person's location is different than the provider's location. Telehealth may be provided by any provider that chooses to use Telehealth.

Coverage will also be provided for Telehealth between a Covered Person and providers that participate with MDLive. Not all Participating Providers participate with MDLive. For a listing of providers that participate with MDLive, Covered Persons may check the participating provider directory by visiting www.mdlive.com or by contacting MDLive, toll free, at 1-866-692-5045.

Telehealth allows a Covered Person to connect with a provider via video conference, telephone or e-mail for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. If your provider utilizes Telehealth he/she will provide you with instructions on how to access that service. Telehealth, through MDLive; however, is an optional service provided under the Plan. To utilize this service, Covered Persons must register by calling MDLive, toll free at 1-866-692-5045, or by visiting www.mdlive.com. MDLive will ask for the primary Covered Person's name, the patient's name (if not calling for yourself), the primary Covered Person's and patient's date of birth and zip code.

Common examples of when to use Telehealth, include, but are not limited to the following:

(1) The Covered Person's primary care doctor is not available.

(2) The Covered Person is traveling and in need of medical care.

(3) During or after normal business hours, nights, weekends and holidays.

(4) To request (non-DEA controlled) prescriptions or refills. Telehealth providers prescribe drugs or medications only if the provider deems it is Medically Necessary.

****Telehealth should only be used for non-emergent situations. If you feel you are in an urgent or life-threatening situation and need immediate assistance, please go to the nearest emergency room****

If you have questions concerning Telehealth or the MDLive program, the available care or coverage, or your benefits, please contact the customer service telephone number on your identification care or MDLive at the telephone number or internet address listed above. In the unlikely event that the Telehealth provider or MDLive is unable to resolve your inquiry, you may, as with any medical service, follow the claim and appeal process that is described in the claim and appeals procedures section of this SPD.

Telehealth services, other than through MDLive, are subject to the same Cost-Sharing as similar services. The Cost-Sharing for services rendered through MDLive is specified in the Schedule of Benefits.

(10) **Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.** Subject to the provisions below, the Plan will provide coverage for the professional component of the following procedures, when rendered and billed by a Health Care Professional: x-ray examinations; radioactive isotope; ultrasound; computerized axial tomography ("CAT") scan; positron emission tomography ("PET") scan; and magnetic resonance imaging ("MRI").

The Plan will provide coverage for a CAT or PET scan or for any other radiation imagery procedure if it is performed by a Health Care Professional in a Facility, and the installation of the equipment required for the CAT or PET scan or other procedure has been approved by law. If the CAT or PET scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority. If the CAT or PET scan or other procedure is performed in a Health Care Professional's office, the Plan will provide benefits for the CAT or PET scan or other procedure only if the New York Public Health Law provides an approval procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

(11) **Radiation Therapy.** The Plan will provide coverage for radiation therapy in an outpatient Facility or in a Health Care Professional's office.

(12) **Chemotherapy.** The Plan will provide coverage for chemotherapy in an outpatient Facility or in a Health Care Professional's office.

(13) **Dialysis.** The Plan will provide coverage for dialysis treatments of an Acute or chronic kidney ailment.

(14) **Infusion Therapy.** The Plan provides coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

(15) **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Plan covers mammograms (including 3D mammograms) for the screening of breast cancer annually for Covered Persons age 35 and over.

If a Covered Person of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Plan covers mammograms as recommended by the Covered Person's provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Diagnostic mammograms (mammograms that are performed in connection with the diagnosis of breast cancer) are unlimited and are Covered whenever they are Medically Necessary.

The Plan also Covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

(16) **Routine Gynecological Services.** The Plan will provide coverage for routine gynecology visits, including coverage for screening for cervical cancer and its precursor states for women 18 years of age and older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines. The screening may be provided in the outpatient department of a Facility pursuant to the Outpatient Care section of the Plan or in a Health Care Professional's office pursuant to this section. At a minimum, the Plan will provide coverage for one screening each Plan Year for women age 18 and older under this section and the Outpatient Care section of this Plan. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(17) **Screenings for Prostate Cancer.** The Plan Covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. The Plan also Covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

(13) **Colonoscopy.** The Plan provides coverage for colonoscopies to screen for colon cancer in an asymptomatic Covered Person in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from the USPSTF.

Diagnostic colonoscopies (colonoscopies that are performed in connection with the treatment or follow-up of colon cancer) are Covered whenever they are Medically Necessary.

(18) **Allergy Testing and Treatment.** The Plan will provide coverage for allergy testing and treatment, including test and treatment materials. Allergy testing includes injections and scratch and prick tests to determine the nature of allergies.

Allergy treatment includes desensitization treatments (injections) to alleviate allergies, including allergens.

(19) **Chiropractic Care.** The Plan will provide coverage for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, such services must be:

(A) Rendered by a provider licensed to provide such services; and

(B) Determined by the Claims Administrator to be Medically Necessary.

The Plan will not provide coverage for maintenance therapy.

(20) **Inpatient Consultations.** The Plan will provide coverage for consultations billed by a Physician subject to the limitations below. A consultation is professional advice given by a Physician to your attending Physician upon request of your attending Physician.

(A) The physician who is called in is a specialist in your illness or disease;

(B) The consultations take place while you are a registered bed patient in a Facility;

(C) The consultation is not required by the rules or regulations of the Facility;

(D) The consulting Physician does not thereafter render care or treatment to you;

(E) The consulting Physician enters a written report in your Facility records; and

(F) Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

(21) **Infertility Services.** The Plan will provide coverage only with respect to diagnostic tests and procedures necessary to determine infertility. Infertility is determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. However, a Covered Person must be between the ages of 21 and 44 (inclusive) as of the date the services are rendered in order to be considered a candidate for these services. The benefits of this section are subject to any applicable Cost-Sharing provisions under this Plan for similar services.

(22) **Bone Density Testing.** The Plan will Cover bone mineral density measurements and tests for the detection of osteoporosis. The Claims Administrator will apply its standards and guidelines that are consistent with the criteria of the federal

Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for bone density testing under this paragraph. Coverage will be provided for tests Covered under Medicare or consistent with the NIH criteria including, as consistent with such criteria, dual-energy x-ray absorptiometry. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Covered Persons:

(A) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(B) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or

(C) On a prescribed drug regimen posing a significant risk of osteoporosis; or

(D) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

(E) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

(23) **Mastectomy Care.** In addition to the surgical services Covered under this section, the Plan will also provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas.

(24) **Mental Health Disorder Outpatient Services.** The Plan Covers outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes only Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a psychiatric nurse, licensed as a nurse practitioner; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof.

(25) **Substance Use Outpatient Services.** The Plan Covers outpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders, , including but not limited to partial Hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling and medication-assisted treatment. Such coverage is limited to Facilities in New York State that are certified or otherwise authorized by OASAS to provide outpatient Substance Use Disorder services, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or

chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a Substance Use Disorder provided by an OASAS credentialed provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also Covers outpatient visits for family counseling. A family member will be deemed to be Covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from alcoholism, substance use and dependency; and 2) and the person receiving, or in need of, treatment for alcoholism, substance use and dependency are both Covered under this Plan. The payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

(1) **Autism Spectrum Disorder.** The Plan will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder:

(A) **Screening and Diagnosis.** Coverage will be provided for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

(B) **Assistive Communication Devices.** Coverage will be provided for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, coverage may be provided for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage will also be provided for software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Claims Administrator will determine whether the device should be purchased or rented.

Repair and replacement of such devices are Covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered; however, coverage will be provided for one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for delivery or service charges or for routine maintenance or the additional cost of equipment or accessories that are not Medically Necessary.

(C) **Behavioral Health Treatment.** Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual will be Covered when provided by a licensed provider. Coverage for applied behavior analysis will also be Covered when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe

measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

(D) **Psychiatric and Psychological Care.** Coverage will be provided for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

(E) **Therapeutic Care.** Coverage will be provided for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise Covered under the Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under the Plan.

For purposes of this section “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

(2) **Treatment of Diabetes.** The Plan will provide coverage for the following equipment and supplies for the treatment of diabetes that the Claims Administrator determines to be Medically Necessary:

(A) Blood glucose monitors;

(B) Blood glucose monitors for the visually impaired;

(C) Data management systems;

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

(E) Injection aids;

(F) Cartridges for the visually impaired;

(G) Insulin pumps and appurtenances thereto;

(H) Insulin infusion devices; and

(I) Additional Medically Necessary equipment and supplies, as determined by the Claims Administrator as appropriate for the treatment of diabetes in accordance with its administrative guidelines.

Repair, replacement and adjustment of the above diabetic equipment and supplies are Covered when made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not Covered.

The Plan will also pay for disposable syringes and needles used solely for the injection of insulin. The Plan will not pay for reusable syringes and needles or multi-use disposable syringes or needles.

The Plan will pay for diabetes self-management education and diet information provided by your Health Care Professional or authorized medical personnel, or their staff, in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by the Claims Administrator. When such education is provided as part of the same office visit for diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. The Plan will also pay for home visits, when Medically Necessary.

Education is also Covered when provided by the following medical personnel (Participating Providers only) upon a referral from your Health Care Professional or authorized medical personnel: certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician or other provider as required by law. Such education must be provided in a group setting, when practicable.

(3) **Durable Medical Equipment, External Prosthetic Devices, Orthotic Devices and Medical Supplies.**

(A) **Durable Medical Equipment.** The Plan will provide coverage for the rental, purchase, repair or maintenance of Durable Medical Equipment and for supplies and accessories necessary for the proper functioning of the equipment. The Plan will provide coverage for Durable Medical Equipment that your physician or other licensed/authorized provider and the Medical Director determines to be Medically Necessary. The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose. The Claims Administrator will determine whether the item should be purchased or rented.

Durable Medical Equipment is equipment that can withstand repeated use; can normally be rented and reused by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Examples of Covered equipment include, but are not limited to: crutches, wheelchairs (the Plan will not pay for motor-driven wheelchairs unless the Claims Administrator determines it is Medically Necessary), a special Hospital type bed, or a home dialysis unit. Examples of equipment the Plan will not Cover include, but are not limited to air

conditioners, humidifiers, dehumidifiers, air purifiers, sauna baths, exercise equipment or medical supplies.

No coverage is provided for the cost of rental, purchase, repair or maintenance of Durable Medical Equipment covered under warranty or the cost of rental, purchase, repair or maintenance due to misuse, loss, natural disaster or theft, unless approved in advance by the Medical Director. No coverage is provided for the additional cost of deluxe equipment that is not Medically Necessary. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary. The Plan will not provide coverage for delivery or service charges, or for routine maintenance.

(B) **External Prosthetic Devices.** The Plan will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. The Plan will Cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator alone will determine if the prosthetic device is Medically Necessary. The Plan will only provide benefits for a prosthetic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost.

A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. External prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; foot orthotics, or arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Not included in this benefit are: the cost of rental, purchase, repair or maintenance of prosthetic devices because of misuse, loss, natural disaster or theft unless approved in advance by the Plan. No coverage is provided for the additional cost of a deluxe device that is not Medically Necessary. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary. The Plan will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.

(C) **Orthotic Devices.** The Plan will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. Orthotic devices include orthopedic braces and custom-built supports, including foot orthotics. The Plan will Cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the orthotic device for your condition before its purchase. Although it is required that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator will determine if the orthotic device is Medically Necessary.

The Plan will only provide benefits for an orthotic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

(D) **Medical Supplies.** The Plan will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and the Claims Administrator determines that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds and burns. Disposable medical supplies: are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves; tracheotomy supplies; and compression stockings. Your physician must order these supplies.

Not included in this benefit are: supplies that are purchased primarily for comfort or convenience; delivery and/or handling charges. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

(4) **Pre-hospital Emergency Services and Transportation.** The Plan will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service certified under the Public Health Law. The Plan will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

(A) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(B) Serious impairment to such person’s bodily functions;

(C) Serious dysfunction of any bodily organ or part of such person; or

(D) Serious disfigurement of such person.

(5) **Ambulance Service.** In addition to the services described in paragraph 4 above, the Plan will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

(A) Ground, water or air ambulance service for an urgent condition to the nearest Hospital where Emergency Services can be performed. When you have an urgent condition, the need for care is less than the need for care of an Emergency Condition, but the condition requires immediate attention. An urgent condition is one that may become an Emergency Condition in the absence of treatment.

(B) Ground, water or air transportation between Facilities when the transport is any of the following:

i From a Non-Participating Provider Hospital to a Participating Provider Hospital;
ii To a Hospital that provides a higher level of care that was not available at the original Hospital;
iii To a more cost effective Acute care Facility; or
iv From an Acute care Facility to a sub-Acute setting.

(C) **Limitations.**

i The Plan does not Cover non-ambulance transportation such as ambulette, van or taxi cab.
ii Coverage for air ambulance related to an Emergency Condition or air ambulance related to a non-Emergency Condition is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
1. The point of pick-up is inaccessible by land vehicle; or
2. Great distances or other obstacles (e.g., heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

(6) **Care in a Freestanding Urgent Care Center.** The Plan will provide coverage for care at a freestanding urgent care center to treat your illness or condition. Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require care from an emergency room department. If you need care after normal business hours, including evenings, weekends or holidays, you have options. You can call your Health Care Professional provider's office for instructions or visit an Urgent Care Center. If you have an Emergency Condition, seek immediate care at the nearest Hospital emergency room department or call 911.

(7) **Preventive Services.** The Plan will provide coverage for the preventive services identified below. To the extent such items and services are Covered elsewhere under this Plan, any Cost-Sharing provisions that may apply will not apply to any Participating Provider.

(A) **Evidence-Based Preventive Services.** Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the USPSTF issued in 2002 will be considered the current recommendations until further guidance is issued by the USPSTF or the Health Resources and Services Administration ("HRSA");

(B) **Routine Immunizations.** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;

(C) **Prevention for Children.** With respect to infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA; and

(D) **Prevention for Women.** With respect to women, such additional preventive care and screenings, not otherwise addressed by the USPSTF, as provided for in comprehensive guidelines supported by HRSA and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services).

(E) **COVID-19 Vaccine:** Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Plan will provide coverage for vaccines and other services intended to prevent COVID-19.

To the extent they are not already Covered Services for women under this Plan, benefits will be provided for all FDA-approved sterilization procedures and generic contraceptive methods. FDA-approved contraceptive methods include prescription drugs, devices and over-the-counter contraceptives when prescribed by a provider legally authorized to prescribe. Coverage for brand name contraceptive methods will also be provided; but only if no generic equivalent is available or the generic equivalent is medically inappropriate for the Covered Person, as determined by a Health Care Professional acting within the scope of his or her license.

A list of the preventive services Covered under this paragraph is available on the Claims Administrator's website at www.excellusbcbs.com or will be mailed to you upon request. You may request the list by calling the Claims Administrator.

(8) **Qualified Clinical Trial Expenses.** The Plan will provide coverage for all health

care items and services for a Covered Person for the treatment of cancer or any other Life-Threatening Condition that is consistent with the standard of care for an individual with the Covered Person's diagnosis; provided, such health care items and services would have been Covered under the Plan if the Covered Person did not participate in the Qualified Clinical Trial. To be eligible for coverage, the Covered Person must meet the requirements of a qualifying individual, as defined below.

For purposes of this section a "qualifying individual" means a Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Condition; and either: (A) the referring Health Care Professional has concluded that the Covered Person's participation in such trial would be appropriate based upon his or her diagnosis; or (B) the Covered Person provides scientific information establishing that the Covered Person's participation in such trial would be appropriate based upon his or her diagnosis.

Notwithstanding the above, Qualified Clinical Trial expenses do not include the following:

(A) the experimental or investigational item, device or service, itself;

(B) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(C) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The benefits of this paragraph are subject to any applicable Deductible, Coinsurance or Copayment provisions for similar services.

(9) **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19.**

Effective as of March 13, 2020, during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), or until such other date determined to be appropriate by the Employer, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

(a) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

(b) the developer has requested, or intends to request, emergency use

authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(c) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

(d) other tests that the Secretary determines appropriate in guidance.

and which have been determined to be medically appropriate for you by your attending provider. In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a Participating Provider or Non-Participating Provider and will not be subject to any Cost-Sharing (i.e. Coinsurance, Copayments or Deductibles), Preauthorization requirements or any other medical management requirements. Other services that you may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Plan Cost-Sharing, Preauthorization and medical management requirements.

(10) **Individual Case Management.**

(A) **Alternative Benefits.** If you agree to participate and abide by the policies of the Plan and the Claims Administrator, in addition to benefits specified in this Plan, you may be provided, outside the terms of the Plan, benefits for services, for up to a 60-day period, furnished by any Participating Provider pursuant to the alternative treatment plan of the Claims Administrator for a Covered Person whose condition would otherwise require Hospitalization.

The Plan may provide such alternative benefits if and only for so long as the Claims Administrator determines, among other things, that the alternative services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total benefits to which you would otherwise be entitled under the Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not obligate the Plan to provide the same or similar benefits for any Covered Person in any other instance where the alternative treatment is not Medically Necessary, cost-effective and feasible, nor shall it be construed as a waiver of the Claims Administrator's right to administer the Plan thereafter in strict accordance with its expressed terms.

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of the Plan. Upon such application for renewal, the Claims Administrator will review the Covered Person's condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and the Claims Administrator's determination will be final.

The alternative benefits you receive will be in lieu of the benefits the Plan would normally provide to you under this Plan for the treatment of your condition. As a result, the Plan may require you to agree to waive certain benefits in order to receive the alternative benefits agreed upon. You may return to utilization of benefits at any time upon prior written notice to the Claims Administrator. However, the benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

(B) **Appeals of Individual Case Management.** If the Claims Administrator denies a request for Individual Case Management, you or your Health Care Professional may appeal by requesting a review of the original decision. Or, if benefits under an individual case management plan are terminated, you or your Health Care Professional may appeal by requesting a review. The request for review may be in writing to:

Corporate Managed Care
165 Court Street
Rochester, NY 14647

Or, you may contact the Claims Administrator's member services department at the phone number located on your identification card.

EMERGENCY SERVICES

(1) **Emergency Services.** The Plan provides coverage for Emergency Services or non-Emergency Services for the treatment of an Emergency Condition or a non-Emergency Condition in a Hospital.

Coverage of Emergency Services or non-Emergency Services for treatment of your Emergency Condition or non-Emergency Condition will be provided regardless of whether the provider is a Participating Provider or Non-Participating Provider. However, the Plan will Cover only those Emergency Services or non-Emergency Services and supplies that are Medically Necessary and, with respect to an Emergency Condition, are performed to treat or stabilize your condition in a Hospital.

(2) **Hospital Emergency Department Visits.** In the event that you require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency department care does not require Preauthorization.

The Plan does not Cover follow-up care or routine care provided in a Hospital emergency department.

HUMAN AND ORGAN BONE MARROW TRANSPLANTS

The Plan will provide coverage for all of the benefits otherwise Covered under this Plan for organ and bone marrow transplants subject to the following limits:

(1) **Care in Approved Transplant Centers.** All transplants must be prescribed by your Specialist and performed at Hospitals that the Plan has specifically approved and designated to perform these type of procedures. The types of organ transplants that are Covered include, but are not limited to: bone marrow; corneal; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact the Claims Administrator if you wish to obtain a list of Hospitals approved and designated by the Plan to perform transplant procedures.

(2) **No Coverage of Experimental or Investigational Transplants.** The Plan will not provide coverage for any transplants determined to be experimental or investigational. You may contact the Claims Administrator if you have a question concerning whether a particular transplant procedure is Covered.

(3) **Recipient Benefits.** The Plan will provide coverage for a person Covered under this Plan for all of the benefits provided to the recipient of the organ transplant that are otherwise Covered under this Plan when they result from or are directly related to a Covered organ or bone marrow transplant.

(4) **Costs of Organ Donor.** The Plan Covers the Hospital and medical expenses of the Covered Person-recipient. The Plan Covers transplant services required by you when you serve as an organ donor only if the recipient is a Covered Person. The Plan does not Cover the medical expenses of a non-Covered Person acting as a donor for you.

(5) **Exclusions.** The Plan does not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor search, screening or fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

(1) **Covered Prescription Drugs.**

The Plan provides coverage for Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a provider authorized to prescribe and within the provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On the Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the

Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of the Formulary. The Formulary is also available at www.Caremark.com. You may inquire if a specific drug is Covered under this Plan by contacting the Prescription Drug Benefit Manager at the number on your ID card.

(2) **Refills.** The Plan Covers Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated Pharmacy as ordered by an authorized provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date.

(3) **Benefit and Payment Information.**

A. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Prescription Drug Schedule of Benefits section of this Plan when Covered Prescription Drugs are obtained from a retail, mail order or Designated Pharmacy.

You have a three (3) tier plan design, which means that your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier one (1) and highest for Prescription Drugs on tier three (3). Your out-of-pocket expense for Prescription Drugs on tier two (2) will generally be more than for tier one (1) but less than tier three (3).

You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-Covered Prescription Drug and any contracted rates (the Prescription Drug Cost) will not be available to you.

B. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or Designated Participating Pharmacy, you are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

C. **Non-Participating Pharmacies.** If you purchase a Prescription Drug

from a Non-Participating Pharmacy, you must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with the Prescription Drug Benefit Manager. The Plan will not reimburse you for the difference between in what you pay the Non-Participating Pharmacy and the Plan's contracted rate for the Prescription Drug. In most cases you will pay more if you purchase Prescription Drugs from a Non- Participating Pharmacy.

D. **Designated Pharmacies.** If you require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, the Plan may direct you to a Designated Pharmacy with whom the Prescription Drug Benefit Manager has an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, you will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Acromegaly;
- Age related macular degeneration;
- AIDS wasting syndrome;
- Allergic Rhinitis
- Anemia, neutropenia, thrombocytopenia;
- Ankylosing Spondylitis;
- Cancer;
- Chorea associated with Huntington Disease;
- Chronic Granulomatous Disease
- Crohn's disease;
- Cystic fibrosis;
- Enzyme deficiencies
- Growth hormone related disorders;
- Hepatitis B;
- Hepatitis C;
- Hereditary Angioedema
- Heterozygous Familial Hypercholesterolemia
- Homozygous familial hypercholesterolemia;
- Hormonal disorders such as endometriosis, precocious puberty, Cushing's Syndrome;

- Hyperkalemia
- Hyperlipidemia
- Idiopathic Pulmonary Fibrosis
- Immune deficiency disorders;
- Infantile Hemangioma
- Infertility;
- Inherited disorders of metabolism;
- Iron overload;
- Juvenile idiopathic arthritis;
- Lipodystrophy;
- Migraine
- Multiple sclerosis;
- Non 24-Hour Sleep Wake Disorder;
- Osteoporosis;
- Parkinson's
- Parkinson's Induced Psychosis
- Peripheral stem cell collection;
- Primary Biliary Cholangitis
- Psoriasis;
- Psoriatic arthritis;
- Pulmonary hypertension;
- Rheumatoid arthritis;
- Seizure disorders such as infantile spasm and refractory complex partial seizures;
- Short bowel syndrome;
- Toxoplasmosis
- Ulcerative colitis;
- Vasoactive intestinal peptide tumors.

E. **Mail Order.** Certain Prescription Drugs may be ordered through a mail order Participating Pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug obtained through a mail order Participating Pharmacy.)

To maximize your benefit, ask your provider to write your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to your home or office.

The Plan will provide benefits that apply to drugs dispensed by a mail order Participating Pharmacy to drugs that are purchased from a retail Participating Pharmacy, including Maintenance Drugs when that retail pharmacy has a participation agreement with the Prescription Drug Benefit Manager in which it agrees to be bound by the same terms and conditions as a mail order Participating Pharmacy.

You or your provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting www.Caremark.com or by calling the number on your ID card.

F. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be made quarterly, but no more than six (6) times per Plan Year, based on the Prescription Drug Benefit Manager periodic tiering decisions. These changes may occur without prior notice to you. However, if you have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) you will be notified. When such changes occur, your out-of-pocket expense may change. You may access the most up to date tier status at www.Caremark.com or by calling the number on your ID card.

G. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand- Name Drug becomes available as a Generic Drug, the tier placement of the Brand- Name Prescription Drug may change. If this happens, you will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned.

H. **Supply Limits.** The Plan will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of one (1) Cost-Sharing amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that has been developed by the Prescription Drug Benefit Manager, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing www.Caremark.com or by calling the number on your ID card. If the Plan denies a request to Cover an amount that

exceeds the quantity level, you are entitled to an appeal pursuant to Claim and Appeals Procedure section of this Plan.

I. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a 15-day supply of your Prescription Order for certain drugs filled at a Designated Pharmacy instead of the full Prescription Order. You initially pay a lesser Cost-Sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Iron Toxicity, Mental/Neurologic Disorders, Oncology, Orphan Drugs,; Inflammatory agents, and Multiple Sclerosis.

This program applies for the first 60 days when you start a new Prescription Drug. This program will not apply upon you or your provider's request. You or your provider can opt out by visiting www.Caremark.com or by calling the number on your ID card.

(4) **Medical Management.** This Plan includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before it can be determined if the Prescription Drug is Medically Necessary.

A. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask your provider to complete a Preauthorization form. Should you choose to purchase the Prescription Drug without obtaining Preauthorization, you must pay for the cost of the entire Prescription Drug and submit a claim to the Prescription Drug Benefit Manager for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please visit www.Caremark.com or call the number on your ID card. The list will be reviewed and updated from time to time. The Plan also reserves the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under the Plan. Your provider may check with the Prescription Drug Benefit Manager to find out which Prescription Drugs are Covered.

B. **Step Therapy**. Step therapy is a program that requires you to try one (1) or more types of Prescription Drug before the Plan will Cover another as Medically Necessary. A "step therapy protocol" means the policy, protocol or program that establishes the sequence in which the Plan will approve Prescription Drugs for your medical condition. When

establishing a step therapy protocol, recognized evidence-based and peer reviewed clinical review criteria is used that also takes into account the needs of atypical patient populations and diagnoses. Certain Prescription Drugs are checked to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list.

(5) **Limitations/Terms of Coverage.** In addition to the General Exclusions section of the Plan, the following limitations/terms of coverage apply:

A. The Plan reserves the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If it is determined that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of Participating Pharmacies may be limited. If this happens, you may be required to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single Participating Pharmacy. If you do not make a selection within 31 days of the date you are notified, a single Participating Pharmacy will be selected for you.

C. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. Please contact your Prescription Drug Benefit Manager at www.Caremark.com or the customer care number 1-888-626-1083 to see if your compounded Prescription Drug requires your provider to obtain Preauthorization.

D. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Covered Persons with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

E. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Plan.

F. The Plan does not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient Care and Professional Services section of this Plan.

G. The Plan does not Cover drugs that do not by law require a prescription, except for smoking cessation drugs , over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF or as otherwise provided in this Plan. The Plan does not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

H. The Plan does not Cover Prescription Drugs to replace those that may have been lost or stolen.

I. The Plan does not Cover Prescription Drugs dispensed to you while in a Hospital, nursing home, other institution, Facility, or if you are a home care patient, except in those cases where the basis of payment by or on behalf of you to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

J. The Plan reserves the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an appeal as described in the Claim and Appeal Procedure section of this Plan.

K. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

(6) **General Conditions.**

A. You must show your ID card to a retail pharmacy at the time you obtain your Prescription Drug or you must provide the pharmacy with identifying information that can be verified by the Prescription Drug Benefit Manager during regular business hours. You must include your identification number on the forms provided by the mail order pharmacy from which you make a purchase.

B. **Drug Utilization, Cost Management.** The Plan conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost- effective manner. In addition, as part of the utilization management activities the

Prescription Drug Benefit Manager (or its designee) may receive rebates from drug manufacturers and may share all or a portion of those rebates with the Plan. Any rebates received by the Plan may be used to offset or reduce administrative fees of the Plan.

GENERAL EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Plan, the Plan will not provide coverage for the following:

(1) **Acupuncture.** The Plan will not provide coverage for acupuncture.

(2) **Biofeedback.** The Plan will not provide coverage for biofeedback.

(3) **Biomechanical Prosthetic Devices.** The Plan will not provide coverage for biomechanical prosthetic devices.

(4) **Blood Pressure Cuff and/or Monitor.** The Plan will not provide coverage for the purchase or rental of a blood pressure cuff and/or monitor.

(5) **Certification Examinations.** The Plan will not provide coverage for any service or care related to a routine physical examination and/or testing to certify health status, including, but not limited to an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport, or adoption.

(6) **Cosmetic Services.** The Plan will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary. Examples of the kinds of services that are often determined to be not Medically Necessary include the following: breast enlargement, rhinoplasty and hair transplants. The Plan will, however, provide coverage for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Plan will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a Child Covered under this Plan that has resulted in a functional defect, and for services in connection with reconstructive surgery following a mastectomy, as provided in the Professional Services section of this Plan.

(7) **Court Ordered Services.** The Plan will not provide coverage for any service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:

A. The service or care would be Covered under this Plan in the absence of a court order;

B. The service or care has been pre-authorized by the Plan, if required; and

C. It is determined, in advance, that the service or care is Medically Necessary and Covered under the terms of this Plan.

This exclusion applies to special medical reports, including those not directly related to treatment, e.g., reports on certification examinations and reports prepared in connection with litigation.

(8) **Criminal Behavior.** The Plan will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

(9) **Custodial Care.** The Plan will not provide coverage for any service or care that is custodial in nature, or any therapy that is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.

(10) **Dental Care.** Except as otherwise provided in the Professional Services section of this booklet, the Plan will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, the Plan will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder, or dental oral surgery. The Plan will, however, provide the benefits set forth in the Plan for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. An injury to a tooth caused by chewing or biting is not considered to be an accidental injury. The Plan will also provide coverage for the services set forth in the Plan that are Medically Necessary for treatment of a congenital anomaly that was present at birth, such as cleft palate and ectodermal dysplasia. Institutional provider services for dental care are also Covered when the Claims Administrator determines there is an underlying medical condition requiring these services.

(11) **Experimental and Investigational Services.** Unless otherwise required by law, the Plan will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if the Service is experimental or investigational.

"Experimental or investigational" means that the Claims Administrator determines the Service is:

A. not of proven benefit for a particular diagnosis or for treatment of a particular condition;

B. not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or

C. not of proven safety for a person with a particular diagnosis or a particular condition, e.g., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well being of a person with the particular diagnosis or in the particular condition.

Governmental approval of a Service will be considered in determining whether a Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean that it is of proven benefit, or appropriate or effective treatment for a particular diagnosis or for a particular condition.

In determining whether a Service is experimental or investigational, the Claims Administrator may require that any or all of the following five criteria be met:

A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.

B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.

D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.

E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in subparagraph C above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

This exclusion will not apply to Qualified Clinical Trial expenses and shall not limit in any way benefits available for prescription drugs otherwise Covered under this Plan which have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of the Claims Administrator's guidelines.

(12) **Free Care.** The Plan will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not Covered under this Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter, or the spouse of any of them, it will be presumed that the service or care would have been furnished without charge. You must prove that a service or care would not have been furnished without charge.

(13) **Government Hospitals.** Except as otherwise required by law, the Plan will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is a Participating Provider. However, coverage will be provided for services or care in such a Facility to treat an Emergency Condition. In this case, coverage will continue to be provided only for as long as emergency care is Medically Necessary and it is not possible for you to be transferred to another Facility.

(14) **Government Programs.** The Plan will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, benefits will be reduced by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if: you fail to enroll in Medicare; you do not pay the charges for Medicare; or you receive services at a Facility that cannot bill Medicare.

However, this exclusion will not apply to you if one of the following applies:

A. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:

(1) The Employee is in "current employment status" (working actively and not retired) with the Employer; and

(2) The Employer maintains or participates in an Employer group health plan that is required by law to have this Plan pay its benefits before Medicare.

B. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

(1) The Employee is in "current employment status" (working actively and not retired) with the Employer; and

(2) The Employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Plan pay its benefits before Medicare pays.

C. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce its benefits, and will provide benefits before Medicare pays, during the waiting period. The Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before the benefits under this Plan are provided.

(15) **Household Fixtures; Disposable Supplies.** The Plan will not provide coverage for:

A. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles; and

B. Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips and bandages purchased for general use); except that this exclusion does not apply to diabetic supplies Covered under the Additional Benefits section of this Plan.

(16) **Hypnosis.** The Plan will not provide coverage for hypnosis.

(17) **Military Service-Connected Conditions.** The Plan will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.

(18) **No-Fault Automobile Insurance.** The Plan will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely

claim for the benefits available to you under a mandatory no-fault policy. The Plan will provide benefits for services Covered under this Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a deductible, the Plan will provide coverage for the services Covered under this Plan, up to the amount of the deductible. The Plan will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

(19) **Non-Covered Service.** The Plan will not provide coverage for any service or care that is not specifically described in this Plan as a Covered Service; or that is related to service or care not Covered under this Plan; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate.

(20) **Personal Comfort Services.** The Plan will not provide coverage for any service or care that is for personal comfort or for uses not primarily medical in nature, including, but not limited to: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers, beauty and barber services, commodes, exercise equipment, arch supports, or orthotics used solely for sports.

(21) **Prohibited Referral.** The Plan will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

(22) **PUVA Therapy.** The Plan will not provide coverage for PUVA (Psoralens and Ultraviolet A) photochemotherapy.

(23) **Reproductive Services.** The Plan will not provide coverage for any of the following reproductive services: artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), costs for an ovum donor or donor sperm, sperm and ova storage costs; cryopreservation and storage of embryos, ovulation predictor kits, or cloning and related costs.

(24) **Reversal of Elective Sterilization.** The Plan will not provide coverage for any service or care related to the reversal of elective sterilization.

(25) **Routine Care of the Feet.** The Plan will not provide coverage for services related to routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet.

(26) **School System Services**. The Plan will not provide coverage for any Covered Services that are available under or covered or provided by an individualized education plan (IEP) or an early intervention program (EIP) or any similar program that is mandated by law or that any school system or state or local

government is required to provide under any law; this applies even if the Covered Person, parent or guardian does not seek such services under an available program or plan. This exclusion does not apply to otherwise Covered Services that exceed the recommendations of or which are not available through the IEP, EIP or other program.

(27) **Self-Help Diagnosis, Training, and Treatment.** The Plan will not provide coverage for any service or care related to self-help or self-care diagnosis, training, and treatment for recreational, educational, vocational or employment purposes.

(28) **Shoe Inserts.** The Plan will not provide coverage for non-custom molded shoe inserts.

(29) **Skilled Nursing Facility.** When Medicare is the primary payor, the Plan will not provide coverage for a Skilled Nursing Facility.

(30) **Special Charges.** The Plan will not provide coverage for charges billed to you for missed appointments, telephone consultations (except telemedicine and telehealth services Covered in accordance with the Excellus BlueCross BlueShield telemedicine and telehealth medical policy or the Telehealth/Telemedicine provision described in the Additional Benefits section of this Plan) new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.

(31) **Social Counseling and Therapy.** The Plan will not provide coverage for any service or care related to family, marital, religious or other social counseling or therapy, except as otherwise provided under this Plan.

(32) **Unlicensed Provider.** The Plan will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.

(33) **Vision and Hearing Therapies and Supplies.** The Plan will not provide coverage for any service or care related to:

A. Eyeglasses, lenses, frames, contact lenses, except for the initial prescription for contact lenses or lenses and frames following cataract surgery; and

B. Routine vision or hearing examination, vision or hearing therapy, hearing aids, vision training, or orthoptics.

(34) **Weight Loss Services.** The Plan will not provide coverage for any service or care in connection with weight loss programs. The Plan will also not provide benefits for any Covered Service or care set forth in this Plan when rendered in connection with weight reduction or dietary control, including, but not limited to,

laboratory services, and gastric stapling, gastric by-pass, gastric bubble, or other surgery for treatment of obesity, unless Medically Necessary.

(35) **Workers' Compensation.** The Plan will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

CONTINUATION OF COVERAGE

Consolidated Omnibus Budget Reconciliation Act of 1985 - COBRA
Family and Medical Leave Act of 1993 (FMLA)
Uniformed Services Employment and Reemployment Rights Act of 1994

This section contains a brief explanation of the Federal laws that permit you and/or your Dependents to continue coverage under the Plan. If you lose coverage under the Plan, contact your Human Resources Department. The Human Resources Department is available to provide a complete description of your right to continue coverage under COBRA, FMLA, or USERRA. Coverage will be identical to that provided by the Plan for active Employees.

COBRA continuation coverage for the Plan is administered by the COBRA Administrator. The COBRA Administrator is:

Lifetime Benefit Solutions, Inc.
P.O. Box 332
Liverpool, NY 13088

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to you and/or your Dependents who become COBRA Beneficiaries.

Eligible COBRA Beneficiaries: You and/or your Dependents that lose coverage under the Plan due to a "qualifying event" will be considered an eligible COBRA Beneficiary unless you, the Employee, were terminated due to gross misconduct. If you are terminated due to gross misconduct and lose coverage under the Plan, you and any of your eligible Dependents will not be entitled to elect to continue coverage under COBRA. An eligible COBRA Beneficiary also includes a new Dependent Child who is born or placed for adoption with a COBRA Beneficiary.

If the "qualifying event" is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a Covered Retiree and his/her Spouse, or surviving Spouse, and his/her eligible Dependents will also be considered a COBRA Beneficiary, provided such bankruptcy results in loss of coverage under the Plan.

Note: You may have other coverage options available to you, other than continuing coverage under COBRA, when you lose coverage under this Plan. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or other group health plan coverage (such as a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

When an Employee is Eligible for COBRA.

If you are an Employee and lose Plan coverage due to termination of employment or a reduction in hours, you and/or your Dependents may continue coverage for up to 18 months, provided you elect to enroll in coverage within 60 days after the later of the date (1) you lose coverage under the Plan; or (2) the date you are given notice of your right to elect COBRA.

When a Dependent is Eligible for COBRA: A Dependent becomes a COBRA Beneficiary if they lose coverage under the Plan due to any one of the qualifying events described below. A Dependent can continue coverage for up to 36 months.

(1) You are a Dependent Child of an Employee and you are no longer eligible for coverage under the Plan as a Dependent Child.
(2) You are a Spouse or Dependent Child of an Employee and you (or your parents in the case of a Dependent Child) become legally divorced, legally separated, or the marriage is legally annulled.
(3) The Employee (your Spouse, or in the case of a Dependent Child, your parent) dies.
(4) The Employee (your Spouse, or in the case of a Dependent Child, your parent) becomes enrolled in Medicare while covered by COBRA.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan, provided he/she notifies the Human Resources Department within 60 days following the date of the qualifying event. Such notification must be provided in accordance with the Notification Requirement provision below.

Extension of COBRA Coverage Due to Disability
A COBRA Beneficiary may be determined totally disabled under Title II or Title XVI of the Social Security Act (SSA) after enrolling for COBRA coverage. If the SSA determines that a COBRA Beneficiary was disabled on the date of the qualifying event or within the first 60 days of COBRA coverage, the disabled COBRA Beneficiary, plus all other COBRA Beneficiaries who are receiving COBRA coverage in connection with the same qualifying event may continue coverage for up to 29 months. The disabled COBRA Beneficiary must apply for and be approved for SSA disability benefits. COBRA Beneficiaries that are not disabled may elect to extend coverage even if the disabled COBRA Beneficiary declines to do so. You must notify your Human Resources Department within 60 days after the date of the SSA determination and before the end of the 18-month COBRA period. If the disabled COBRA Beneficiary is no longer determined disabled by SSA, you must notify your Human Resources Department within 30 days after the date of the SSA determination. Any Such notification must be provided in accordance with the Notification Requirement provision below.

Extension of COBRA Coverage Due to another Qualifying Event
If a second qualifying event occurs during the first 18 months of COBRA coverage, your Spouse and any Dependent Child may continue coverage for up to 36 months from the date of the original qualifying event. You must notify the Human Resources Department within 60 days of a qualifying event that causes a Dependent to lose coverage under the Plan. Such notification must be provided in accordance with the Notification Requirement provision below.

When Continued Coverage Ends: Continued coverage will end for any COBRA Beneficiary on the earliest of the following dates:

(1) The date cost of continued coverage is not paid when it is due.
(2) The date the COBRA Beneficiary becomes enrolled in Medicare after their COBRA election date under this Plan.
(3) The date the person becomes covered under any other health plan after their COBRA election date under this Plan.
(4) The date the Plan terminates and the Plan Sponsor ceases to provide group health plan coverage.
(5) The maximum period of extension under COBRA ends (18, 29, or 36 months).
(6) The first of the month beginning 30 days after the date of the SSA's determination that a COBRA Beneficiary is no longer disabled.

Notice Requirements: Each COBRA Beneficiary has an independent right to elect COBRA coverage, even if an Employee rejects COBRA coverage. The COBRA Beneficiary must request continued coverage by providing written notice to the Human Resources Department that is postmarked within the time frames listed above. Failure to elect COBRA during the timeframes described above will result in the loss of all rights to continue coverage for the benefits available under this Plan.

It is very important to keep the Plan Administrator informed of the current address of all Covered Persons who are or may become qualified COBRA Beneficiaries. You may notify the Plan Administrator at the address in the section entitled "General Plan Information".

For qualifying events such as divorce, annulment or legal separation of the Employee and Spouse, death of an Employee or former Employee, or a Dependent Child's loss of eligibility under the Plan, the notification must contain the following information:

(1) Name of the Plan;
(2) Name and address of the Employee or former Employee who is or was Covered under the Plan;
(3) Name and address of all COBRA Beneficiaries who lost coverage due to the qualifying event;
(4) A detailed description of the qualifying event;
(5) Date of the qualifying event; and
(6) Include any documentation providing proof of the event (e.g. divorce decree).

For second qualifying events, in addition to all of the required information stated in (1) through (6) above, the notice must also include the following information:

(1) Name and address of all COBRA Beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of this notice; and

(2) Describe the nature and date of the initial qualifying event.

For a determination by SSA that you, your Spouse or Dependent Child is determined to be disabled within 60-days after your COBRA coverage begins, the notice must contain the information stated in (1) through (6) above, in addition to the following:

(1) Name of the disabled COBRA Beneficiary;

(2) Date upon which the disabled COBRA Beneficiary became disabled;

(3) Date upon which the SSA made its determination of disability; and

(4) A copy of the determination of the SSA.

If you, your Spouse or Dependent Child is later determined by SSA to be not disabled, the notification to the Human Resources Department must include all of the above stated information, in addition to the following:

(1) Date upon which the COBRA Beneficiary is considered no longer disabled; and

(2) Date upon which the SSA made its determination of non-disability status.

If the notice does not contain all of the required information, the Human Resources Department may request additional information from you. If you fail to provide the required information within the timeframe specified in the request, your notice may be rejected and no continuation of coverage under this provision or extension of coverage (if applicable) will be provided.

Notification must be sent to the Human Resources Department at the following address:

Syracuse City School District
1025 Erie Blvd. West
Syracuse, NY 13204

Cost of COBRA Coverage: Any person who elects to continue coverage under the Plan must pay 102% of the actual cost of coverage you elect, unless you qualify for the 11-month disability extension. Any person that elects the 11-month disability extension will be required to pay 150% of the actual cost of coverage for the 11-month extension period. If election is made after the Covered Person becomes eligible for COBRA, the first payment must be paid within 45 days of the election. It must Cover the entire period prior to the election. Payments are then due on the first day of each month to continue coverage for that month. If payment is not received by the due date, coverage will be cancelled and cannot be reinstated. The cost of the continued coverage will be determined by a method defined by law. Calculation of COBRA premiums is made annually and may increase or decrease based on Plan experience.

FMLA and USERRA Continuation Coverage: If an Employee is on a leave of absence because of the Family and Medical Leave Act of 1993 (FMLA) or if an Employee is absent from active service by reason of “service in the uniformed services,” within the meaning of Section 4303(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employee may elect continued

coverage for a specified period of time. For more information on FMLA or USERRA continuation coverage contact your Employer.

COORDINATION OF BENEFITS

This section applies only if you also have other group health benefits coverage with another plan.

(1) **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be Covered by both plans, the Plan will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

(a) Any group or blanket insurance contract, plan, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

(b) Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization or Employee benefit organization;

(c) Any Blue Cross, Blue Shield or other service type group plan;

(d) Any coverage under governmental programs or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

(e) Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

(2) **Rules to Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:

(a) If the other plan does not have a provision similar to this one, then it will be primary;

(b) If you are covered under one plan as an employee, subscriber, or primary member and you are only covered as a Dependent under the other plan, the plan which covers you as an employee, subscriber, or primary member will be primary; or

(c) Subject to the provisions regarding separated or unmarried parents below, if you are covered as a Child under both plans, the plan of the

parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

(d) There are special rules for a Child of separated or unmarried parents:

i. If the terms of a court decree specify which parent is responsible for the health care expenses of the Child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

ii. If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the Child's health care expenses does not have actual knowledge of the court decree, benefits for the Child are determined in the following order:

a. First, the plan of the parent with custody of the Child;

b. Then, the plan of the spouse of the parent with custody of the Child;

c. Finally, the plan of the parent not having custody of the Child.

(e) If you are covered under one of the plans as an active Employee, neither laid-off nor retired, or as the Dependent of such an active Employee, and you are covered as a laid-off or retired Employee or a laid-off or retired Employee's Dependent under the other plan, the plan covering you as an active Employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

(f) If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.

(3) **Payment of the Benefit When This Plan Is Secondary.** When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other plan and this Plan do not exceed the Allowed Amount for an item of service. However, the Plan will not pay more than it would have paid if it were primary.

The Plan counts as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. The Employer and/or the Claims Administrator will request information from that plan so the Claims Administrator can process your claims. If the primary plan does not respond within 30 days, the Claims Administrator may assume that the primary plan's benefits are the same as the Plan's. If the primary plan sends the information after 30 days, the Plan will adjust its payment, if necessary.

Although it is not a requirement of this section, when you have coverage under more than one health plan, you can help to maximize the benefits available to you by following the rules and protocols of both the primary and secondary plans.

(4) **Right to Receive and Release Necessary Information.** The Plan, the Employer and the Claims Administrator have the right to release or obtain information that they believe necessary to carry out the purpose of this section. The Plan, the Employer and the Claims Administrator need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. The Plan, the Employer and the Claims Administrator will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish any information that the Plan, the Employer and the Claims Administrator request. If you do not furnish the information, the Plan has the right to deny payments.

(5) **Payments to Others.** The Plan may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which the Employer and/or the Claims Administrator decide the Plan should have paid. These payments are the same as benefits paid.

(6) **The Plan's Right to Recover Overpayment.** In some cases the Plan may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to the Plan the amount by which it should have reduced the payment it made. The Plan also has the right to recover the overpayment from the other health benefits plan if the Plan has not already received payment from that other plan. You must sign any document that the Employer and/or the Claims Administrator deems necessary to help the Plan recover any overpayment.

SUBROGATION/REIMBURSEMENT PROVISION

The purpose of this Plan is to provide benefits for expenses that are not Covered by another party. All payments made under this Plan are conditioned on the understanding that the Plan will be repaid (either through reimbursement or subrogation) for benefits that related to an illness, injury or health condition for which you (or your estate, legal guardian or legal representative), may have or assert for a tort or contractual recovery. Recovery rights apply to any sums you receive by settlement, verdict, or otherwise for the illness, injury or health condition.

This Plan is always secondary to any recovery you make from Worker's Compensation (no matter how the settlement or award is characterized for damages) and is always secondary to any automobile coverage for first party benefits.

If you assert a claim against or receive money from another responsible person or insurance company or other party in connection with an illness, injury or health condition for which you have received benefits under this Plan, you must contact the Employer immediately.

The Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your own). The amount of such subrogation will equal the total amount paid under the Plan arising out of the illness, injury or health condition that is the basis for any claim you (or your estate, legal guardian or legal representative) may have or assert. The Plan may assert its subrogation rights independently of you or it may choose to assert its reimbursement rights against your recovery.

The Plan has the right to reimbursement to the extent of benefits paid related to the illness, injury or health condition from any recovery you may receive from these sources regardless of how your recovery is characterized or regardless of whether medical expenses are specifically included in your recovery. The Plan shall recover the full amount of benefits advanced and paid for the illness, accident, or injury without regard to any claim or fault on your part.

The Plan's subrogation and reimbursement rights are a first priority lien on any recovery meaning the Plan is entitled to recover up to the full amount of benefits it has paid without regard to whether you (or your estate, legal guardian or legal representative) have been made whole or received full compensation for your other damages and without regard to any legal fees or costs that you (or your estate, legal guardian or legal representative) have paid or owe. In other words, the Plan's right of recovery shall not be reduced due to the "Double Recovery Rule", "Made Whole Rule", "Common Fund Rule" or any other legal or equitable doctrine. The Plan's right of recovery takes preference over any other claims against the recovery and is enforceable regardless of how settlement proceeds are characterized.

You (or your estate, legal guardian or legal representative or other person acting on your behalf) must hold recovery funds from any person or party in constructive trust for the benefit of the Plan.

You agree to cooperate with the Plan’s reimbursement and subrogation rights as the Plan may request and you agree not to prejudice the Plan’s rights under this provision in any manner.

CLAIM AND APPEAL PROCEDURES

You or your provider must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Plan Administrator or the Claims Administrator.

When submitting a claim form, include:

(1) The name of the patient;
(2) The name, address, telephone number and tax identification number of the provider;
(3) The name of the Employee;
(4) The place where the services were rendered;
(5) The diagnosis and procedure codes;
(6) The amount of charges;
(7) The name of the Plan; and
(8) The date of service.

Payments will be made directly to Participating Providers. Payments for services rendered by a Non-Participating Provider may be payable directly to the Non-Participating Provider or the Employee. Submit claim forms to the Claims Administrator at:

For Medical Claims:

Excellus Health Plan, Inc.
P.O. Box 21146
Eagan, MN 55121

For Prescription Drug Claims:

Print a claim form when you log in to www.Caremark.com.
Download the CVS/Caremark Mobile App to help manage you claims as well.
You can also call the customer service number on the back of your ID Card for assistance.

Timely Claim Filing Requirement
All claims must be filed with the Plan within 12 months after you receive the services for which payment is being requested. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the U.S. Department of Labor's claims procedure regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those regulations, those regulations will control. In addition, any changes in those regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, you or your authorized representative must follow the procedures outlined in this section. There are four (4) different types of claims: (1)

Post-service claims; (2) Pre-service claims; (3) Concurrent care claims; and (4) Urgent care claims.

Post-Service Claims
Post-service claims are those claims that are filed for payment of benefits after health care has been received. If your post-service claim is denied, you will receive a written notice from the Plan within 30 days of receipt of the claim, as long as all needed information was provided with the claim. This 30-day period may be extended by the Plan for up to 15 days. In addition, the Plan will notify you within the initial 30-day period if additional information is required to process the claim, and will put your claim on hold until all information is received.

Once notified of the extension and the additional information required to process the claim, you have 45 days to provide the required information. If all of the required information is received within the 45-day time frame and the claim is denied, the Plan will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims
Pre-service claims are those claims that require notification or approval prior to receiving health care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan within 15 days of receipt of the claim.

If the Plan determines, in its discretion, that special circumstances require an extension of time for processing the claim, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. Such an extension generally will not exceed 15 days. However, if the extension is necessary because of your failure to provide required information you shall have 45 days to provide the information.

If all of the needed information is received within the 45-day time frame, the Plan will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims
Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

(1) You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Plan receives all necessary information, taking into account the seriousness of your condition.

(2) However, if your urgent care claim is missing required information, the Plan will notify you of the omission and how to correct it within 24 hours after the urgent

care claim was received. You will then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

(1) The Plan's receipt of the requested information; or

(2) The end of the 48-hour period within which you were to provide the additional information requested.

Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided by the Plan within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Plan shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Adverse Benefit Determination
If a claim is wholly or partially denied, or if a rescission of coverage occurs, the Plan will furnish the Plan participant with a written notice of the adverse benefit determination. The written notice will contain the following information:

(1) the specific reason or reasons for the adverse benefit determination;

(2) specific reference to those Plan provisions on which the adverse benefit determination is based;

(3) a description of any additional information or material necessary to complete the claim and an explanation of why such material or information is necessary;

(4) notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(5) A statement describing your right to request an external review (if applicable), or if applicable, to bring an action for judicial review;

(6) In the case of an adverse benefit determination by the Plan:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;

(b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

(7) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(8) In the case of an adverse benefit determination, the Plan must:

(a) Ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and provide notice of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) Ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

(c) Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(d) Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Appealing a Denied Claim

If you disagree with a claim determination after following the above steps, you can contact the Plan in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your

claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Plan will identify, upon request to the Plan, any medical experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

(1) The patient's name and the identification number from the ID card,

(2) The date(s) of service(s),

(3) The provider's name,

(4) The reason you believe the claim should be paid, and

(5) Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Claims Administrator at the following address:

For Medical Appeals:

Excellus Health Plan, Inc.
P.O. Box 4717
Syracuse, NY 13221.
Fax Number: 1-315-671-6656

For Prescription Drug Appeals:

Print an appeal form when you log in to www.Caremark.com.
Download the CVS/Caremark Mobile App to help manage you claims as well.
You can also call the customer service number on the back of your ID Card for assistance.

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or

not medically necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan will provide the claimant (i.e. you and your Covered Dependents), free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which:

(1) You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and

(2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review
For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be counted from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Appeal Process
A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Health Care Professional with appropriate expertise in the field who was not involved in the prior determination. The Plan may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Your participation in the Plan includes your consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right

to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

(1) **Pre-Service and Post-Service Claim Appeals**

You will be provided with written notification of the decision on your appeal as follows:

For appeals of pre-service claims (as defined above), your appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

For appeals of post-service claims (as defined above), your appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

(2) **Urgent Claim Appeals**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your doctor should call the Plan as soon as possible. The Plan will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Manner of Notification of Final Internal Adverse Benefit Determination

The Plan shall provide a participant with written notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the participant:

(1) The specific reason or reasons for the adverse benefit determination;

(2) Reference to the specific Plan provisions on which the adverse benefit determination is based;

(3) A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

(4) A statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures;

(5) A statement of the participant's right to bring an action for judicial review; and

(6) The following information:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific

rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant upon request; and

(b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

(7) In the case of an adverse benefit determination the Plan must:

(a) Ensure that any notice of final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) Ensure that the reason or reasons for the final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim. This description must also include a discussion of the decision;

(c) Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(d) Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Adverse Benefit Determination

For purposes of the Plan's claim procedures, an "adverse benefit determination" is a denial, reduction or termination of, or a failure to provide or make payment (in whole, or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction of termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to Cover an item or service for which benefits are otherwise provided because it is determined be experimental and/or investigation or not medically necessary or appropriate. Adverse benefit determination also includes a rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

External Review
You have the right to an "external review" of certain coverage determinations made by the Plan. An external review is a request for an independent review of a coverage determination by a third party known as an Independent Review Organization (IRO). IROs must be accredited by a nationally-recognized accrediting organization and must be assigned to review appeals pursuant to independent, unbiased selection methods. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage. You may request an external review only if the requested service is Covered by the Plan.

You may have the right to an expedited external review if the timeframe for completion of an expedited internal appeal or a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function. Also, you have the right to an expedited external review in connection with final adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received Emergency Services, but have not been discharged from a Facility. If coverage is denied on the basis that the requested service is experimental or investigational, and your treating physician certifies that the requested service would be significantly less effective if not promptly initiated, you may request an expedited external review. The timeframes for determining expedited external reviews are shorter than the timeframes for standard external reviews.

Coverage Determinations Subject to External Review. This subparagraph describes the general conditions for external review.

In general, you may not request an external review unless the Plan has issued a "final adverse determination" of your request for coverage through the internal appeal process. However, if you qualify for an expedited external review, you may also file an expedited external review at the same time as filing an expedited internal appeal. You are also eligible for an external review if both parties have agreed to an external review even though you have not obtained a final adverse determination.

To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered benefit, or that the requested service is experimental or investigational, or for a rescission of coverage. For purposes of this section a rescission of coverage is a retroactive termination of coverage under the Plan, except in cases where you fail to pay any required contribution to the cost of coverage under the Plan. You do not have the right to an external review of any other determinations, even if those other determinations affect your coverage.

Requesting an External Review. If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing a self-insured external review request form with the Plan. The Plan will send the external review application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to

submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external review.

You must file your request for an external review with the Claims Administrator within four months of receiving a final adverse determination.

Upon receipt of a request for an external review, the Plan must determine if the request meets the requirements for external review and will notify you of its eligibility determination. Upon a determination that the request is eligible for external review, the Plan will assign the appeal to an IRO for review.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Questions. If you do not understand any part of the external review process or if you have questions regarding your right to external review, you may contact the Employee Benefits Security Administration at 1-866-444-3272.

Time to Sue
No action at law or in equity may be maintained against the Plan or the Claims Administrator to recover benefits under the Plan prior to the expiration of 60 days after written submission of a claim for such benefits has been furnished to the Plan as required in this Plan. In addition, no legal action may be commenced or maintained to recover benefits under the Plan more than three (3) years after the date you received the service for which you want the Plan to pay.

Appointment of Authorized Representative
An authorized representative is a person you authorize, in writing, to act on your behalf with respect to a benefit claim and/or appeal a denial of benefits. It also means a person authorized by a court order to submit a benefit claim and/or appeal a denial of benefits on your behalf. An assignment of benefits by you to a provider will not constitute appointment of that provider as your authorized representative. To appoint an authorized representative, you must complete a form that can be obtained from the Plan Administrator or the Claims Administrator. However, for a claim involving urgent care, a Health Care Professional with knowledge of your condition may always act as your authorized representative without completion of this form.

TEMPORARY TOLLING OF CERTAIN TIMEFRAMES

Effective as of March 1, 2020, the Plan will disregard days occurring during the "Outbreak Period" (as defined below), for purposes of determining the date by which an individual (e.g., a participant, claimant, dependent, qualified beneficiary) has to:

a. request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
b. elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
c. make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
d. provide a required notice to the Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
e. file an initial claim for benefits under the Plan if the timely filing period otherwise would include any day of the Outbreak Period;
f. file an internal or external appeal (if applicable) in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
g. perfect a request for external review (if applicable) in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (a)-(g) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a covered person has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 30-day special enrollment period, if the special enrollment period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 30-day period (leaving 16 days in the special enrollment period), (ii) the entire Outbreak Period (March 1, 2020 through February 28, 2021) will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period, on March 16, 2021.

Coverage with respect to (b) and (d) above, may be retroactive to the date of the qualifying event; provided the covered person makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the "Outbreak Period" is the period beginning on the later of (1) March 1, 2020 or (2) the "Applicable Event Date" (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after the announced end of the "National Emergency" described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the "Agencies")) and will be interpreted

to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020 (and any subsequent guidance from the Agencies). The "National Emergency" for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period with respect to a specific event or all events, if applicable, will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

For purposes of this section, the "Applicable Event Date" is determined under the following chart, based on which event (from events (a) through (g) above) has occurred:

Event	Event type	Applicable Event Date
(a)	Special enrollment event	First day of special enrollment period
(b)	Initial COBRA election	First day of 60-day COBRA election period
(c)	Initial COBRA payment Monthly COBRA payment	First day of 45-day initial payment period First day of 30-day payment grace period
(d)	COBRA qualifying event notice	First day of 60-day period for providing notice
(e)	Initial claim	Date of claim
(f)	Internal or external appeal	Date of receipt of claim denial
(g)	Perfection of external appeal	Date of receipt of notice of need for information

RESPONSIBILITIES OF THE PLAN ADMINISTRATION

Named Fiduciary
The named fiduciary of this Plan is the Plan Sponsor.

The Plan Sponsor has full discretionary authority to control and manage the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan. The Plan Sponsor delegates its responsibility with respect to the payment of claims to the Claims Administrator. The Claims Administrator is the named fiduciary with respect to the determination of claims and appeals under the Plan.

Appointment of Plan Administrator
The Plan Administrator is appointed by the Plan Sponsor. The Plan is administered by the Plan Administrator. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonable possible. If no Plan Administrator is appointed, then the Plan Administrator is the Plan Sponsor.

Authority to Make Decisions
The Plan Administrator has full discretionary authority to administer and interpret the Plan, including discretionary authority to interpret its terms, make determinations of fact, and determine eligibility for participation and benefits under the Plan. The Plan Administrator may, however, delegate its discretionary authority and such duties and responsibilities as the Plan Administrator deems appropriate to facilitate the day-to-day administration of the Plan. Any determination of the Plan Administrator or its delegate is binding, final and conclusive upon all persons. In carrying out its duties with respect to the general administration of the Plan, the Plan Administrator has, in addition to the foregoing powers and any other powers conferred by this Plan, or by law, the following powers:

(1) to construe the terms of the Plan and to determine all questions arising in its administration, interpretation, application or operation;

(2) to decide all questions relating to the eligibility of individuals to participate in the Plan;

(3) to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed items;

(4) to determine the benefits under the Plan to which any person may be entitled;

(5) to keep records of all acts and determinations of the Plan Administrator and to keep all such records, books, accounts, data and other documents as may be necessary for the proper administration of the Plan;

(6) to prepare and distribute to all participants information concerning the Plan, and the rights of the participants under the Plan, including, but not limited to, all information which is required to be distributed under state or federal law;

(7) to perform all necessary reporting as required by state or federal law;

(8) to employ counsel, accountants and other consultants to aid in exercising its powers and carrying out its duties under the Plan; and

(9) to perform any other acts necessary and proper for the administration of the Plan.

Amendment or Termination of the Plan

The Plan Sponsor has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the terms and conditions of any relevant collective bargaining agreements.

If the Plan is terminated, the rights of a Covered Person are limited to expenses incurred before the termination date. All amendments to the Plan shall become effective as of the date established by the Plan Sponsor.

GENERAL PROVISIONS

Assignment of Benefits
You cannot assign any benefits or monies due under the Plan to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Plan or your right to collect money from it for those services.

Notice. Any notice that the Employer or the Claims Administrator give to you under this Plan will be mailed to your address as it appears on the such entities records or to the address of the Employer. If you have to give the Employer or Claims Administrator any notice, it should be mailed to the address listed in the General Plan Information section.

Your Medical Records. In order to provide your coverage under this Plan, it may be necessary for the Employer and/or the Claims Administrator to obtain your medical records and information from Facilities, Health Care Professionals, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Plan, you automatically give the Employer and/or the Claims Administrator permission to obtain and use those records for those purposes.

The Employer and the Claims Administrator agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give the Employer and the Claims Administrator permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Employer and the Claims Administrator contract to assist them in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Who Receives Payment under this Plan. Payments under this Plan for service provided by a Participating Provider will be made directly by the Plan (or by the Claims Administrator on behalf of the Plan) to the provider. If you receive services from a Non-Participating Provider, payment may be made to either you or the provider at the option of the Employer or the Claims Administrator.

Venue for Legal Action. If a dispute arises under this Plan, it must be resolved in Federal court, or a court located in the State of New York. You agree not to start a lawsuit against the Plan or the Claims Administrator in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action the Plan or Claims Administrator brings against you.

Choice of Law. All disputes relating to this Plan shall be governed by Federal law and, as applicable, the laws of the State of New York.

Recovery of Overpayments. On occasion a payment will be made when you are not Covered, for a service that is not Covered, or which is more than is proper. When this happens the Employer and/or the Claims Administrator will explain the problem to you and you must return the amount of the overpayment within 60 days after receiving notification.

Right to Offset. If the Plan makes a claim payment to you or on your behalf in error or you owe the Plan any money, you must repay the amount you owe. If the Plan owes you a payment for other claims received, the Plan has the right to subtract any amount you owe to the Plan from any payment the Plan owes you.

Agreements between the Claims Administrator and Participating Providers. Any agreement between the Claims Administrator and Participating Providers may only be terminated by the Claims Administrator or the providers. This Plan and the Claims Administrator do not require any provider to accept a Covered Person as a patient. Neither the Plan, nor the Employer nor the Claims Administrator guarantees a Covered Person's admission to any Participating Provider or any health benefits program.

Identification Cards. Identification cards are issued for identification only. Possession of any identification card confers no right to services or benefits under this Plan. To be entitled to such services or benefits the Covered Person's contributions must be paid in full at the time that the services are sought to be received. Coverage under this Plan may be terminated if the Covered Person allows another person to wrongfully use the identification cards.

Right to Develop Guidelines and Administrative Rules. The Employer and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Plan. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this Plan. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator and it will explain the standards or send you a copy of the standards. The Employer and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Employer and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Plan. Any actions or decisions made by the Employer and/or the Claims Administrator are binding unless arbitrary, capricious or made in bad faith.

Furnishing Information and Audit. All persons Covered under this Plan will promptly furnish the Employer and/or the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Plan. You must provide the Employer and/or the Claims Administrator with information over the telephone for reasons such as the following: to allow the Employer and/or the Claims Administrator to determine the level of care you need; so that the Employer and/or the Claims Administrator may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

Enrollment. The Employer will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all Covered Persons Covered under this Plan, and any other information required to confirm their eligibility for coverage. The Employer will provide the Claims Administrator with the enrollment information including your name, address, age and social security number and advise the Claims Administrator in writing when you are to be added to or subtracted from the list of Covered Persons, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

Reports and Records. The Employer and the Claims Administrator are entitled to receive from any provider of services to Covered Persons, information reasonably necessary to administer this Plan subject to all applicable confidentiality requirements as defined in the General Provisions section of this Plan. By accepting coverage under this Plan, the Employee of the Employer, for himself or herself, and for all Covered Dependents Covered hereunder, authorizes each and every provider who renders services to a Covered Person hereunder to:

(1) Disclose all facts pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

(2) Render reports pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional, that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim; and

(3) Permit copying of the Covered Person's records by the Employer and the Claims Administrator.

Service Marks. Excellus Health Plan, Inc. ("Excellus") is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Service Contract between the Employer and Excellus.

Inter-Plan Arrangements Disclosure - Out-of-Area Services. The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the Claims Administrator's Service Area, the claims for

these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside the Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Non-Participating Providers. The Claims Administrator's payment practices in both instances are described below.

(1) **BlueCard® Program.** Under the BlueCard® Program, when you access Covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible to Employer for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.
Whenever you access Covered health care services outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered health care services is calculated based on the lower of:

(2) The provider's billed Covered charges for your Covered Services; or

(3) The negotiated price that the Host Blue makes available to the Claims Administrator. This negotiated price will be one of the following:

(a) Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;

(b) Sometimes, an estimated price that takes into account special arrangements with your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or

(c) Occasionally, an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any Covered health care services according to applicable law.

(4) **Calculation of Covered Person Liability for Services of Non-Participating Providers outside the Claims Administrator's Service Area.** The Allowed Amount definition in this Plan, as amended from time-to-time, describes how the Claims Administrator's payment (the "Allowed Amount") for Covered Services of Non-Participating Providers outside its Service Area is calculated. The Allowed Amount may be based upon the amount provided to the Claims Administrator by the Host Blue or the payment it would make to Non-Participating Providers inside its Service Area. Regardless of how the Allowed Amount is calculated, you will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowed Amount, which amount is in addition to any other Cost-Sharing (Deductible, Copayment or Coinsurance) required by this Plan.

Qualified Medical Child Support Orders: The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order". A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

(1) Relates to the provision of Child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or

(2) Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from your Employer.

Services will not be Denied Based on Gender Identity. The Plan will not limit coverage or impose additional cost sharing for any otherwise-Covered Services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the gender for which such health services are ordinarily available. In such cases, the Plan generally will rely on recommendations of the treating physician, Excellus BlueCross BlueShield medical policies, and applicable legal guidance to determine if a particular service is Medically Necessary.

Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

(1) Reconstruction of the breast on which the mastectomy was performed, or

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

(3) Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

The above-described coverage required by the law may only be subject to the annual Deductibles, Copayments, and Coinsurance provisions that apply to similar benefits. If you would like more information on WHCRA, please contact your Human Resources Department.

The Genetic Information Nondiscrimination Act of 2008 (GINA). GINA is a federal law that prohibits discrimination in group health plan coverage based on Genetic Information. This Plan is maintained and operated in a manner consistent with GINA.

The Mental Health Parity Addiction and Equity Act of 2008 (MHPAEA). The MHPAEA is a federal law that generally prevents group health plans that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. In accordance with MHPAEA, this Plan maintains parity between Covered medical/surgical benefits and Covered mental health and substance use disorder benefits relating to financial Cost-Sharing restrictions and treatment-duration limitations. For additional information, please contact the Plan Administrator.

Certification of Compliance with Privacy Regulations: A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information that is maintained or received by the Plan. Such information is referred to as Protected Health Information

(PHI) in this section. A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices (Privacy Notice) you received when you enrolled. A copy of the Privacy Notice is available upon request from the Employer.

Under HIPAA you have certain rights with respect to your PHI, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the PHI under certain circumstances.

The Plan may disclose PHI to the Employer only as follows:

Summary Health Information. The Plan may disclose PHI that is summary health information to the Employer, if the Employer requests the summary health information for the purpose of obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan or amending the Plan. "Summary health information" is Plan information that summarizes claims information for the Plan from which most individual identifying information has been removed.

Enrollment Information. The Plan may disclose to the Employer information on whether an individual is participating in the Plan.

Other Disclosures to Employer. Except as provided above or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Employer only if the Employer requires the PHI to administer the Plan. The Employer, by signing this Plan document, certifies that it:

(1) will not use or further disclose PHI other than as permitted by the Plan or as required by law;

(2) will ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;

(4) will report to the Plan any use or disclosure, of which it becomes aware, of PHI that is inconsistent with the uses or disclosures permitted under the Plan;

(5) will make PHI available to the individual who is the subject of that information in accordance with the Privacy Regulations;

(6) will consider requested amendments to an individual's PHI in accordance with the Privacy Regulations;

(7) will make available the information required to provide an accounting of disclosures of PHI in accordance with the Privacy Regulations;

(8) will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(9) if feasible, will return or destroy all PHI received from the Plan that the Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) will ensure that the adequate separation of the Plan and the Employer as required in this Section is established.

Prohibited Disclosures. The Plan will not disclose PHI to the Employer for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

Separation of Health Plan and the Employer. The Employer has designated and trained certain Employees to be the only Employees of the Employer who will have access to PHI. Only those trained and authorized Employees will use or disclose PHI on behalf of the Plan and only to the extent appropriate for performing administrative services that the Employer provides for the Plan.

The Employer will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that Employees of the Employer who have access to PHI use that PHI only for the purposes specified in this Section.

Privacy Notice. The Plan will comply with the applicable requirements of the Plan's Privacy Notice, which is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan. You may request a copy of the Notice of Privacy Practices from the Employer or the Privacy Officer.

Security Regulations. The Plan will comply with all applicable requirements of the HIPAA Security Regulations.

In addition, the Employer, by adopting this document, certifies that it will

(1) Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan;

(2) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(3) Ensure that the adequate separation of the Employer and the Plan required by the Privacy Regulations is supported by reasonable and appropriate security measures;

(4) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect that information; and

(5) Report to the Plan any security incident of which it becomes aware.

Breach Reporting. The Employer will promptly report to the Plan any breach of unsecured PHI of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HIPAA Security Breach Regulations.

GENERAL PLAN INFORMATION

PLAN NAME:	Syracuse City School District Health Benefits Plan
PLAN SPONSOR:	Syracuse City School District 1025 Erie Blvd. West Syracuse, NY 13204
PLAN SPONSOR EIN:	15-6010157
TYPE OF PLAN:	Welfare benefit plan providing medical and prescription drug benefits
PLAN ADMINISTRATOR	Syracuse City School District 1025 Erie Blvd. West Syracuse, NY 13204 1-315-425-4171
SOURCES OF CONTRIBUTIONS:	Syracuse City School District(Employer) and its Employees contribute funds
COBRA ADMINISTRATOR:	Lifetime Benefit Solutions P.O. Box 332 Liverpool, NY 13088
UTLIZATION REVIEW MANAGER:	Excellus Health Plan, Inc. 165 Court Street Rochester, NY 14647
MEDICAL CLAIMS ADMINISTRATOR:	Excellus Health Plan, Inc. P.O. Box 21146 Eagan, MN 55121
PRESCRIPTION DRUG BENEFIT MANAGER	CVS Caremark P.O. Box 6590 Lee's Summit, MO 64064-6590 1-888-626-1083
PLAN YEAR:	July1- June 30.
SOURCE OF FUNDING:	The Plan is self-funded and all benefits are paid from the general assets of the Employer .
AGENT FOR SERVICE OF LEGAL PROCESS	Syracuse City School District 1025 Erie Blvd. West Syracuse, NY 13204

PRIVACY OFFICER:	Chief Accountability Officer Syracuse City School District 1025 Erie Blvd. West Syracuse, NY 13204 1-315-435-4281

EXHIBIT A- NOTICE REGARDING PREMIUM ASSISTANCE UNDER MEDICAID OR SCHIP

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.