PRE-CERTIFICATON REQUIREMENTS

Certain services provided by this Plan require that you notify the case management consultant prior to obtaining the service. The purpose of this notification is to enable you and/or your medical provider to obtain confirmation that the service or hospitalization qualifies as a Covered Service under this Plan. Failure to notify will not automatically result in denial of a claim if the charges are for Medically Necessary services or supplies, and are charged in accordance with UCR. However, your cooperation is appreciated when pre-certification is requested. The case management consultant will provide a notice confirming coverage within three days after receiving the necessary Information.

FOR PRE-CERTIFICATION, CALL CORPORATE CARE MANAGEMENT AT 607-648-3400 OR 800-541-7403.

BENEFIT DETERMINATIONS DO NOT CONSTITUTE MEDICAL ADVICE

The Plan's determinations as to coverage of specific treatments or procedures (services) should not be taken as medical advice. The fact that a particular service is covered or not covered should not be interpreted to mean that the Plan is either recommending or not recommending that the Covered Person undergo the treatment or procedure. This decision is solely up to the Covered Person, with the necessary advice of his physician or other medical provider. A denial of coverage means only that the service is not a covered benefit, and that if the person chooses to undergo the treatment or procedure, he will be responsible for the full cost of that treatment or procedure.

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

Your Employer is providing health benefits to you through the self-funded Catskill Area Schools Employee Benefit Plan (CASEBP). This booklet is your plan document and summary plan description, and it provides information on your Plan benefits and your responsibilities to provide information to the Plan for proper administration of your medical claims. Any apparent conflict between this document and any other publication or presentation involving this Plan will be resolved by reference to this Plan document.

School Districts Participating in the Plan:

- Andes Central School
- Charlotte Valley Central School
- Cherry Valley/Springfield Central School
- Cooperstown Central School
- Delaware Academy
- Edmeston Central School
- Gilboa-Conesville Central School
- Hunter-Tannersville Central School
- Jefferson Central School
- Laurens Central School
- Margaretville Central School
- Milford Central School
- Morris Central School
- Roxbury Central School
- Schenevus Central School
- Sidney Central School
- South Kortright Central School
- Stamford Central School
- Windham-Ashland-Jewett Central School
- Otsego-Northern Catskill BOCES
- Worcester Central School

Board of Directors: The Board of Directors, which is the governing committee of the Plan, consists of the Superintendent (or his designee) from each of the participating Employer School Districts.

Plan Administrator: The Plan Administrator is the President of the Board of Directors of CASEBP, located at 2020 Jump Brook Road, Grand Gorge, NY 12434. Phone: 607-588-8917.

Health Plan Coordinator: The CASEBP Plan Coordinator is Darleen Callahan, PO Box 383, Grand Gorge, NY 12434. Phone 607-588-8917 or 800-962-6294.

Claims Administrator: Claims are administered by CASEBP, PO Box 383, Grand Gorge, NY 12434. Phone: 607-588-8917

or 800-962-6294.

Case Management Consultant: Corporate Care Management, 1 Kattelville Rd., Binghamton, NY 13901. Phone: 607-648-3400 or 800-541-7403.

Pharmacy Benefit Manager: Express Scripts. Phone: 800-711-0917.

Privacy Official/Security Official: The Plan's Privacy and Security Official is the Coordinator of Health and Dental Claims Administration located at CASEBP, P.O. Box 383, Grand Gorge, NY 12434. Phone: 607-588-8917.

Plan Effective Date -The effective date of this Plan is October 1, 1981. The Restated Plan's effective date is January 1, 2006.

Plan Fiscal Year: The Plan's fiscal year ends each June 30th

Agent for Service of Process - CASEBP Plan Administrator, 2020 Jump Brook Road, Grand Gorge, NY 12434.

Coverage under the Group Plan: CASEBP provides the benefits described in this document to eligible Employees and Retirees, as well as their eligible Dependents. Many of these benefits are currently mandated by New York State Insurance Law and Regulation. If State mandates change in the future, certain benefits described herein may be increased, reduced or even eliminated by way of plan amendments adopted by the CASEBP Board of Directors, and approved by the State Insurance Department.

SECTION 2

DEFINITIONS

Throughout this booklet, certain words and phrases may be capitalized. Those terms are defined in this section.

BIOLOGICALLY BASED MENTAL ILLNESS – a mental, nervous or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under the law, only the following disorders satisfy the definition of "biologically based mental illness": schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia and bulimia.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES – means those persons under the age of 18 years who have a diagnosis of attention deficit disorders, disruptive behavior disorders or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors, significant psychotic symptoms (hallucinations, delusion, bizarre behaviors), behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage or behavior cause by emotional disturbances that place the child at substantial risk of removal from the household.

CONFINEMENT - means admission to a Facility as an inpatient due to injury or Illness. Successive periods of Confinement for the illness or Injury will be considered as one continuous period of Confinement unless separated by a period of 90 days or more during which the Covered Person has not been confined to a Facility.

COSMETIC SURGERY- means surgery to improve an individual's appearance, which is not considered Reconstructive

Surgery. Cosmetic surgery usually includes procedures like breast enlargement or reduction, liposuction, rhinoplasty, ear pinning and facial lifts, or other surgery not considered Medically Necessary.

COVERED CHARGE - means the amount of Covered Expenses, before any applicable deductible or co- payment that will be covered by the Plan. If the Professional Provider is an "in-network provider", the Coverage Charge will be based on the provider's negotiated rate. If the Professional Provider is "out-of-network", the Covered Charge will be the lesser of the Usual, Customary and Reasonable rate or the Provider's actual charges. The Covered Person is responsible for any expenses that are not considered Covered Charges.

COVERED EXPENSES - means those costs incurred for Covered Services, treatments, or supplies which are reimbursable under the Plan. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not necessarily make it a Covered Expense. Even though it may not specifically be listed as an exclusion, an expense may be non-reimbursable under this Plan.

COVERED PERSON - means an Employee, Retiree, or Dependent who is covered for benefits under this Plan.

COVERED SERVICES - means those Medically Necessary services described in Section 5 of this Plan, as well as those services that may not be Medically Necessary but are specifically covered under those sections, such as mammograms, cervical cytology screening and well child care.

CUSTODIAL CARE - means any service or supply that is custodial in nature, or any therapy that we determine 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 other such related activities. The Plan may review medical records and progress periodically to determine whether care is or has become Custodial Care. Custodial Care is not covered by the Plan.

DEPENDENT - means an Employee's or (Retiree's) spouse or a child who meets the eligibility requirements for coverage in Section 3.

EMERGENCY MEDICAL CONDITION/TREATMENT - means Medically Necessary emergency care for a sudden or unexpected onset of an acute sickness or condition either medical or behavioral, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent person, possessing an average knowledge of medicine and health, could reasonably result in the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a pregnant woman, placing the health of her unborn child in serious jeopardy; or (b) serious impairment of the person's bodily functions; or (c) serious dysfunction of any bodily organ or part of the person; or (d) serious disfigurement of such person.

EMERGENCY SERVICES –means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate and Emergency Condition and within the capabilities of the staff and facilities available at the Hospital and further medical evaluation and treatment are required to stabilize the patient. Emergency Services are not subject to prior authorization.

EMPLOYEE - means, at a minimum, a person who is directly employed in a regular business of an Employer member of this Plan, who receives W-2 compensation from the Employer, and who meets the Employer's requirements for eligibility for health coverage under the Plan. Eligibility requirements may vary among participating employers.

EMPLOYER- means one of the school or BOCES districts participating in the Plan.

EXPERIMENTAL and/or INVESTIGATIONAL- means those treatments, procedures, drugs, biological products, or medical devices ("Services"), which are not generally covered by this Plan. See p. 32 for additional information and an explanation of Experimental and Investigational exclusions.

FACILITY - means a Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; home health agency or home health care services agency certified or licensed under Article 36 of the New York Public Health Law; an Institutional provider of mental health or chemical dependence and abuse treatment, operating under Article 31 of the Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or any other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable).

HOSPITAL- means any short-term acute general hospital facility which:

1 - is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, those diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick patients;
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 - is 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 section 1861(k) of United States Public Law 89-97, {42 USCA 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, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

MAINTENANCE CARE - means continuing care where there is no evidence of improvement of the condition being treated, and the schedule of visits for care is not consistent with an acute pattern of treatment.

MEDICALLY NECESSARY- means those treatments, procedures, drugs or supplies (Services) required to diagnose or treat a Covered Person's medical condition, as determined in accordance with accepted medical practices and standards. The fact that a provider has furnished, prescribed, ordered, recommended or approved the Service does not make it Medically Necessary or mean that the Plan must provide coverage for it. The Plan will determine whether care was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. 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, we will also consider the following:

- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of the attending Professional Providers (which have credence but do not overrule contrary opinions; and

- Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- They are appropriate and consistent with the diagnosis and treatment of your medical condition;
- They are required for the direct care and treatment or management of that condition;
- If not provided, your condition would be adversely affected;
- They are provided in accordance with community standards of good medical practice;
- They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
- They are the most appropriate Service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
- 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).

Service or care must be approved standard treatment. Except as otherwise required by law, or as provided in the Plan, no service or care rendered to you will be considered Medically Necessary unless we determine that the service or care is consistent with 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. See Section 9 for your right to an external appeal of our determination that service or care is not Medically Necessary.

PROFESSIONAL PROVIDER- means a certified and licensed physician, osteopath, dentist, optometrist, chiropractor, registered psychologist, psychiatrist, social worker, podiatrist, physical therapist, occupational therapist, licensed midwife, speech-language pathologist, audiologist or any other licensed health care provider that the New York Slate Insurance Law requires to be recognized who charges and bills patients for his or her services. A Professional Provider's services must be rendered within the lawful scope of his practice in order to be covered under this Plan.

RECONSTRUCTIVE SURGERY - means surgery limited to improving or restoring bodily function, or correcting a deformity which has resulted in a functional impairment caused by disease or trauma; or a congenital or developmental abnormality of a covered Dependent child.

Women's Health and Cancer Rights Act (WHCRA) Notice - If a Covered Person is receiving benefits in connection with a mastectomy, reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce a symmetrical appearance, will be considered Reconstructive Surgery and will be a Covered Expense. See Section 5 for additional details.

ROUTINE FOOT CARE - means cutting or removal of corns, or calluses, the trimming of nails (including mycotic nails) and other hygienic and preventative maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bed patients, and any services performed in the absence of localized injury, illness or symptoms involving the feet.

SKILLED CARE- means a service which we determine is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by Medicare guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

SKILLED NURSING FACILITY - means a facility accredited as a Skilled Nursing Facility by the Joint Commission on

Accreditation of Healthcare Organizations or qualified as a Skilled Nursing Facility under Medicare. We will provide coverage in a Skilled Nursing Facility only the care is determined by us to be Skilled Care (see above).

SPOUSE - means a person to whom you are legally married under the laws of the State or country in which the ceremony took place. Neither "common law" marriage partner, a "domestic partner" nor a partner in a "civil union" will be considered a "spouse" for purposes of dependent eligibility under the Plan. Proof of marriage acceptable to the Plan will be required for enrollment of a spouse.

TIMOTHY' S LAW – means the legislation that mandates benefits for persons suffering from "biologically based mental illness" and/or "children with serious emotional disturbances" as defined in this section of the Plan. If this law is amended or repealed by the New York State Legislature, the benefits mandated by the law will be amended or repealed accordingly by action of the Plan's Board of Directors with approval from the State Insurance Department.

TOTALLY DISABLED- means, when referring to an Employee, that the Employee is unable to perform the substantial and material duties of his occupation or employment or the duties of any other employment for which he is reasonably qualified by training and experience and at comparable wages. During unemployment, a Covered Person will be considered Totally Disabled if he is unable, because of illness or injury, to perform the duties of any employment for which he is reasonably qualified by training and experience. A Dependent Spouse will be considered Totally Disabled if he is completely unable, as a result of Injury or illness, to engage in the usual, customary, substantial and material activities engaged in prior to the onset of disability. A Dependent child will be considered totally disabled if he is completely unable, as a result of injury or illness, to engage in normal activities of children of similar age.

USUAL AND CUSTOMARY AND RESONABLE (UCR) - means a fee or charge determined by the Plan based on charge data collected from recognized sources that conforms to the range of fees or charges charged by most providers qualified to provide the Covered Services and receive payment under the Plan for the particular Covered Service in the geographic area where the service is received.

SECTION 3

ELIGIBILITY AND ENROLLMENT INFORMATION

Who Is Eligible? Employees and their Dependents, and Retirees and their Dependents may be eligible for coverage under this Plan. Board members of member school districts may also be eligible.

Employee Eligibility. The Plan has established certain minimum eligibility requirements for Employees. However, your Employer may adopt more restrictive eligibility requirements within certain limits. Contact your Employer Plan representative for Employer-specific eligibility requirements. Minimum eligibility requirements are as follows:

(1) The Employee must have been hired for an anticipated period of at least three months; and

(2) The Employee must work a regularly scheduled work week of 20 or more hours and be paid a minimum annual salary of at least $2,000.00.

Employees may enroll for either individual or family coverage at the time of hire. If an Employee's spouse works for another Employer member of this Plan, the Employee and Spouse may each elect Individual coverage, family coverage, or supplemental coverage.

Dependent Eligibility. If you have family coverage, the following members of your family may also be covered as Dependents:

(1) The Employee's legal Spouse (see definition of "spouse").
(2) An Employee's biological children, step-children, adopted or pre-adoptive* children and eligible foster children (those who are placed with the employee by an authorized agency or order of a court of competent jurisdiction), regardless of marital status, financial dependence, residence or student status. Eligibility ends when the child reaches his or her 26th birthday. (Only the Employee's child is eligible, not the child's spouse or children)

*A "pre-adoptive" child refers to a child under the age of 18 as of the date of the placement for adoption whom the Employee intends to adopt, whether or not the adoption has become final. The Employee must have assumed and retain a legal obligation for total or partial support of the child in anticipation of the adoption of the child. The child must be "available" for adoption and the legal process of adoption must have begun. \

Note: Dependents who meet the above qualifications and who were terminated from the plan prior to July 1, 2011 (including those who may have elected COBRA coverage) may re-enroll as dependents during the Plan's regular open enrollment period or during the initial 30-day open enrollment period beginning in July 1, 2011.

(3) Children other than those described above in sub-section (2) who reside with the Employee may also be eligible under some circumstances; however, in the case of a child who is not the Employee's biological, step-, foster, adoptive or pre-adoptive child as described above, that child must receive more than half of its support from the Employee and be eligible to be claimed as a deduction on the Employee's income tax return. These children are eligible for coverage only until the age of 19 (or 25 if they are full-time students).

To qualify for student coverage, a child as described in section (3) above must be dependent on his parent(s) for support, and be enrolled as a full time student taking at least 12 credit hours at an accredited two or four-year college or university. Proof of enrollment during each semester must be submitted to the Claims Administrator or Health Plan Coordinator when requested to ensure continued coverage; otherwise benefits may be reduced or denied.

The following will also constitute attendance at an accredited college or university:

(a) Full time enrollment in correspondence or on-line courses if the course work is intended to lead to a college or university degree.
(b) Full time enrollment in a trade school, such as beauty school, or other institution from which one obtains a license as opposed to a degree.

Attendance in a BOCES or other high-school alternative program will *not* constitute continued eligibility for students age 19 and older.

The employee must present proof that the student qualifies as a dependent under IRS regulations prior to and following each year the student is in school in order for coverage to continue.

If a dependent student is granted a medical leave from school, coverage will continue for a maximum of 12 calendar months following the month in which the child withdraws from school, plus the time between the end of that period and the beginning of the next regular semester (unless the child otherwise loses eligibility as a student during that time or loses eligibility for any other reason).

In order to continue coverage during this period, the Plan must receive periodic written certification from the child's treating physician that (1) the child is suffering from a serious illness or injury or (2) the leave of absence from the institution is Medically Necessary.

Time spent in military service, not to exceed four years, may be deducted from the Dependent's age for the purpose of establishing eligibility for coverage.

(4) An Employee's unmarried disabled child may also be covered under the Plan, regardless of age, if the child is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or developmental disability as defined in the New York State Mental Hygiene Law, if the child is chiefly dependent upon the Employee. This disabling condition must have occurred before the child reached the age at which coverage under the Plan would have otherwise terminated. The child's disability must be certified by a physician within 31 days after he reaches the age at which coverage would have terminated in order for coverage to continue under the Plan. The Plan has the right to check whether a child is and continues to qualify under this paragraph, including whether he qualifies as a dependent of the Employee's under IRS regulations.

A child who lives with an Employee on a temporary basis, such as an exchange student or a foster child is not eligible for benefits. We have the right to request and be furnished with any proof we need to determine eligibility status of prospective Dependents as they pertain to eligibility under this Plan.

Note: If an Employee does not have family coverage and elects to enroll any dependents, then the Employee must elect family coverage and contribute to that cost of the coverage in order to cover any qualified dependents.

Retiree Eligibility. If an Employer offers retiree medical benefits, the Employee must purchase either (1), an individual policy, or (2), two individual policies (for himself and his spouse) at the time of retirement. If he has Dependents when he retires, he may elect to retain family coverage until the children are no longer Dependents. At that time, he must drop family coverage and purchase either one individual policy covering himself, or two individual policies covering himself and his spouse. If a husband and wife each work for a district participating in the plan, the Employee who retires may purchase two individual policies at retirement, rather than a family policy.

Employees who waive coverage for themselves and/or their dependents for any reason at the time of retirement generally may not elect coverage later. (Check with your Employer to verify his policy on this Issue because your contract may provide additional benefits.) To maintain your coverage in this Plan after retirement, it must be elected at the time of retirement. If you elect not to cover your spouse at the time of retirement, you may not obtain coverage for any spouse or dependent at a later date unless you are entitled to add a Dependent under the federal law known as HIPAA.

Young Adult Children of Employees. Young adult children of Employees may be eligible for coverage under the Plan if the following requirements are met:

1. The Employee must be actively enrolled in the Plan or covered by COBRA;
2. The Young Adult must be over the age of 26 and under the age of 30;
3. The Young Adult must be unmarried, work or reside in the Plan's service are or New York and does not have to live with or be financially dependent on the parent;

4. The Young Adult may not be eligible for Medicare or for coverage under his own employer's health plan. The young adult is eligible for single coverage, not coverage for his dependents.

Proof of Eligibility will be required by the Plan at the time of enrollment. The cost of the coverage will be equal to the total contribution for coverage (employer and employee combined) for single coverage under the Plan.

Enrollment Dates for Coverage. Eligible young adults may enroll in the Plan under the following circumstances:

1. Loss of Dependent Coverage under the Plan. If the young adult is currently covered as a dependent under the employer's policy, he may enroll within 60 days of the date that coverage would otherwise end due to reaching the maximum age for dependent coverage. Coverage will be retroactive to the date coverage would otherwise have terminated.

   Note: Coverage will be *retroactive* only if elected within 60 days of the date the adult would otherwise age off a parent's policy. In all other cases, coverage would be *prospective* and will start no more than 30 days from the date that the Plan receives notice of election and payment of coverage.

2. Changes in Circumstances. The young adult may enroll within 60 days of newly meeting the eligibility requirements because of a change in circumstance. Coverage will be prospective and will start 30 days of when the Employer receives notice of election and payment of coverage.
3. During an Annual 30-day Open Enrollment Period. If the Plan has an open enrollment period each year, young adults who meet eligibility requirements can enroll in the Plan. Coverage will be prospective and will start 30 days of when the Plan receives notice of the election and payment for coverage.

When Does Coverage End? Coverage will end when any one of the following situations occurs:

1. Coverage is terminated pursuant to the terms of the Plan.
2. The parent-employee is no longer enrolled in the Plan or COBRA.
3. The young adult no longer meets the eligibility requirements.
4. The cost of the coverage is not paid on time or within the 30 day grace period.
5. The school district's health plan is terminated and not replaced.

Note: Once benefits under this option have ended, there is no COBRA extension available to the young adult.

Disability Retirement. If an Employer provides retiree coverage and. an Employee is granted a disability retirement due to disability arising out of and in the course of his employment, he may continue health coverage regardless of his age or length of employment. If the Employee is granted a non-employment connected disability retirement, he may also continue coverage if he has the required years of employment (as determined by each individual Employer).

Vested Status and Retiree Coverage. If an Employee terminates his employment with a participating Employer before retirement age, he may be eligible to continue coverage under the Plan while in "vested" status, and then into retirement. However, to be eligible, the Employee must have (1) satisfied the minimum requirements established by law for vesting his retirement allowance, and (2) meet the minimum requirements for continuation of health coverage into

retirement at the time of employment termination (except for age). These requirements may not be satisfied while the Employee is in vested status, or after the Employee's retirement allowance begins. In addition, an Employer who offers coverage to its retirees may require that the Employee be within five years of retirement at the time he vests.

Vestees must pay the full cost of coverage. After a vestee becomes eligible to receive his retirement allowance, he will be required only to pay the retiree's share of the cost. If there is any interruption in coverage during vested status (such as for failure to remit payment for coverage), the vestee may lose his retirement continuation coverage. Check with your Employer for their policy in this regard.

Coverage for Employees on Authorized Leave without Pay. Employees on authorized leave without pay may be able to continue coverage under this Plan; however, they may be required to pay both the Employer and Employee shares of the cost of coverage directly to their Employers. Consult your Employer for details on the extension of coverage while on leave without pay.

Coverage for Disabled Employees. Employees who become Totally Disabled due to illness or injury, and who remain Totally Disabled for a continuous period of three months, may be eligible to continue coverage under the Plan for up to one year (not all employees are eligible for continued coverage. Check with your own employer to find out if you are eligible). In order to be eligible for a waiver of premium during that time, the Disabled Employee must be on authorized leave without pay, and not be receiving income through salary, sick leave accruals or retirement allowance. The Employee must apply for a waiver of premium, and keep coverage in effect by paying premiums prior to his application for a waiver. A waiver of premium may continue for up to 12 months, but will terminate if any of the following events occurs: the Employee returns to the payroll; the Employee terminates employment; the Employee (or Dependent) dies; the Employee's disability ceases; or, the Employee retires. If Medicare eligibility occurs in the three months before or during the waiver period, Medicare will become primary coverage for the Employee, and this Plan will be secondary. If you fail to enroll in Medicare when eligible, your benefits will be paid as if you had actually enrolled.

Coverage for Survivors of Employees or Retirees. If an Employee or Retiree dies while covered for benefits under this Plan, the surviving Dependents are entitled to continue coverage for three months beyond the last month for which contributions were made on the Employee/Retiree's behalf. This coverage is provided at no cost to the survivors (the school district will make the Employee/Retiree's contribution). COBRA continuation rights will begin after the expiration of survivor benefits.

Once COBRA has been exhausted, the surviving Dependents will be eligible to continue coverage under the Plan **if the deceased Employee/Retiree had at least 10 years of service prior to his death**. The spouse will remain eligible for coverage until he or she remarries, provided he pays the full cost of coverage. Dependent children will remain eligible for as long as they would have been eligible had their Employee/Retiree parent lived.

Board Member Eligibility. Board of Education members of participating school districts are eligible for coverage under the Plan. After 20 years of service on the Board, they may continue coverage as if they were retirees. Board members must pay the full cost of coverage. When they become eligible for Medicare, they must enroll, or the Plan's payments will be reduced as if they were actually enrolled and receiving Medicare benefits.

Open Enrollment in Plan. During the month of October of each year, Employees are permitted to transfer from other Employer-sponsored health plans or HMO's. Although some Employers have different policies, changes in enrollment generally become effective on January 1' 1 of the year following the date of transfer to this Plan. However, if an Employee and his Dependents are enrolled in an HMO, and permanently move to an area not served by that HMO, they may enroll in this Plan at that time without regard to open enrollment dates.

Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009. Employees and Dependents who are eligible, but not already enrolled in this Plan may enroll when either

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

WHEN COVERAGE BEGINS

Employees. A new Employee's effective date of coverage is established by his Employer. Coverage may begin on the first day of employment or at a later date. Check with your Employer for their policy regarding effective dates of coverage under the Plan.

An Employee who waives coverage when he is first eligible, or loses coverage for failure to pay required contributions, may elect to resume coverage on the earlier of the first day of the month following a three-month waiting period, or during the Plan's open enrollment period.

Dependents (other than newborns). Employees may elect family (Dependent) coverage when (1) they acquire a spouse or child who meets the definition of Dependent on pgs. 10-11, or (2) they wish to enroll a previously eligible but un-enrolled spouse or child who meets the definition of Dependent on pgs. 10-11.

An Employee must apply for family coverage within 30 days after his coverage becomes effective, or the date he acquires a Dependent, in order for coverage to become effective on the first day of the month following application. Otherwise, family coverage will not begin until the first day of the third month following application. (In some cases, coverage may begin on the date of marriage, or the date the Employee acquires a Dependent child. Application for first day coverage must be made in advance).

An unborn child will not be eligible for coverage as a Dependent until the date of the child's birth. However, medical and/or surgical intervention of the unborn child to prevent or correct a congenital defect will be considered a maternity expense, as long as the maternity expenses related to that child are Covered Expenses under the Plan, and the treatment is not Experimental or Investigational as defined in the Plan.

Newborn Coverage. If an Employee has family coverage, his newborn Dependent child will automatically become covered as a Dependent on the date of his birth. However, the newborn's eligibility for coverage will terminate 30 days after birth unless the Claims Administrator has received enrollment materials by that date.

If the Employee does not have family coverage at the time of the infant's birth, the infant will still be covered if the Employee elects Dependent medical coverage, effective as of the first day of the month in which the child was born, and he submits enrollment materials (which are received by the Claims Administrator) not later than 30 days after the birth. The contribution payment must be received by the Claims Administrator on or before the 301 day of the month following the month in which the birth occurs.

Newborn coverage will be provided to the same extent as it is for other covered Dependent children. The Plan

pays Covered Expenses for Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, as well as Hospital charges for routine nursery care.

A newborn adopted child is covered from birth provided that the Employee takes physical custody of the child as soon as he is released from the Hospital after birth, and that the Employee files a petition for adoption (pursuant to the New York State Domestic Relations Law, Section 115-C) within 60 days of the infant's birth. In addition, coverage will be provided only if no notice of revocation of the adoption has been filed and only if consent to the adoption has not been revoked. In no instance will the Plan pay for the adopted infant's Hospital stay if either of the biological parents has medical coverage available for the infant.

WHEN COVERAGE ENDS.

Employees. Your coverage as an Employee under this Plan ends at 11:59:59 pm on the last day of the month in which the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The day your employment ends; or

(2) The day your status as an eligible Employee ends; or

(3) The last day of the month immediately preceding the month in which you, or your Employer on your behalf, made any required contribution; or

(4) The day your Employer stops participating in the Plan or otherwise terminates your coverage; or

(5) The day you enter the armed forces of any country, except as otherwise required by Section 4317 of the Uniformed Services Employment and Reemployment Rights Act (USERRA) (membership in the reserves is not deemed entry into the armed forces); or

(6) The day the Plan terminates.

Dependents. Your coverage as a Dependent ends at 11:59:59 pm on the last day of the month in which the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The day the Employee's coverage under the Plan ends; or

(2) The day the Employee ceases to be in a class of Employees eligible for Dependent coverage; or

(3) The last day of the month immediately preceding the month in which the Employee, or the Employer on behalf of the Employee and covered Dependent, made any required contribution; or

(4) The day Dependent coverage is canceled; or

(5) The day you no longer qualify as a Dependent (or Student Dependent) under the Plan; or

(6) The day you enter the armed forces of any country, except as otherwise required by Section 4317 of the Uniformed Services Employment and Reemployment Rights Act (USERRA) (membership in the reserves is not deemed entry into the armed forces); or

(7) The date of the Employee's death (unless you are entitled to survivor benefits; see page 12, Coverage of Survivors of Employees or Retirees); or

(8) The day the Plan terminates.

Retirees. Your coverage as a Retiree and your Dependent's coverage will end when the first of the following events occurs, (except as provided in any extension of coverage provision):

(1) The Retiree or the former Employer fails to timely pay the applicable cost of the Retiree's coverage; or

(2) The Plan terminates; or

(3) The Dependent coverage terminates under the Plan; or

(4) The Retiree dies (unless you are entitled to survivor benefits; see page 12, Coverage of Survivors of Employees or Retirees

Temporary Extension of Benefits. If a Covered Person is totally disabled or pregnant, or the disability coverage terminates, benefits for the care of that disability or pregnancy will be available for up to 12 months or until the disability or pregnancy ends, whichever occurs first. If the person becomes covered under another plan, including, but not limited to, coverage under no-fault or workers' compensation insurance, the other plan will be primary for coordination of benefits purposes.

SECTION 4

COBRA CONTINUATION COVERAGE

Federal statutes require the Plan to offer special health benefit continuation rights to certain Covered Persons, if coverage is lost due to certain specified occurrences. This law is commonly known as COBRA. The events that will give the Covered Person the option to choose this COBRA continuation coverage are known as "qualifying events." A "qualified beneficiary'' Is the person eligible for coverage due to a qualifying event.

Qualifying Events. If you are an Employee, you will become a qualified beneficiary under the Plan if you lose coverage because either of the following events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you become a qualified beneficiary if you lose coverage because any of the following events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his gross misconduct;

(4) Your spouse becomes entitled to Medicare benefits (Part A or B or both); or

(5) You become divorced or legally separated from your spouse.

Dependent children will become qualified beneficiaries if they lose coverage because any of the following events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his gross misconduct;

(4) The parent-employee becomes entitled to Medicare Part A or B, or both;

(5) The parents become divorced or legally separated; or

(6) The child no longer meets the definition of Dependent under the Plan.

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If your Employer files a proceeding in bankruptcy, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Claims Administrator has been notified that the qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits under Part A, Part B or both, the Employer must notify the Claims Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For the other qualifying events (divorce or legal separation of the Employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Employer within 60 days after the qualifying event occurs, and your Employer will notify the Claims Administrator.

How is COBRA Coverage Provided? Once the Claims Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Length of COBRA Coverage. COBRA continuation coverage is a temporary continuation of coverage that may last for as long as 36 months, unless terminated early due to one of the reasons listed below.

Early Termination of COBRA Coverage. The maximum period of COBRA coverage may be shortened, and coverage terminated early for any of the following reasons:

1) the Employer ceases to provide any group health coverage to any Employee (including successor plans);
2) the qualified beneficiary fails to make timely payment of his required contribution for coverage;
3) the qualified beneficiary becomes entitled to Medicare (after the date of his COBRA election); or
4) the qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan

maintained by another Employer that does not exclude or limit coverage for a qualified beneficiary's pre-existing medical condition.

Cost of COBRA Coverage. Employees and other Covered Persons who elect to continue benefits through COBRA will pay 102% of the combined Employee/Employer contribution. The initial payment must be received by the 451 day after the COBRA election. Subsequent payments must be made in advance and no less frequently than quarterly.

If You Have Questions. Questions concerning COBRA continuation coverage rights under this Plan should be addressed to the Claims Administrator. For general information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Conversion Rights. After COBRA coverage terminates, a Covered Person may be able to obtain an individual "conversion" policy, if one is available at the time. However, the policy offered may not offer the same benefits as this Plan. If conversion coverage is available, the person seeking the coverage has 45 days after COBRA terminates to elect it. There is no conversion policy available for prescription drug benefits.

SECTION 5

HOSPITAL AND BASIC PLAN BENEFITS

SCHEDULE OF BENEFITS AND LIMITATIONS

BASIC BENEFITS. The Plan will pay the benefits described in this section on behalf of Covered Persons, provided the benefits are Medically Necessary and not excluded elsewhere in this document. Certain limitations and requirements for coverage may apply, which are described in the Schedule of Benefits and in this section.

In cases where an alternative procedure, service or Medically Necessary treatment can be performed to properly treat an illness or injury, the Plan may provide coverage if the alternative treatment is more cost- effective or medically sound, even if the alternative treatment is not a Covered Benefit under the Plan. Decisions about alternative treatment will be authorized by the Plan Administrator in consultation with the case management consultant and the patient.

Pre-certification by a Case Management Consultant Is requested for all inpatient hospitalizations and certain other services as Indicated In this Plan document.

Inpatient Care in a Hospital. The Plan provides coverage for 365 days of Hospital care for each Confinement as a Basic Benefit. Additional days of Confinement may be paid as a Non-basic benefit. There are certain limitations on coverage for mental health care, inpatient detoxification in an alcohol rehabilitation center, skilled nursing care, rehabilitation and chemical dependency. These limitations are described elsewhere in this document.

A single Hospital confinement means one or more inpatient admissions to a Hospital. When you are admitted to a Hospital after at least 90 days during which you have not been confined in any Hospital, Skilled Nursing Facility or similar Facility, the admission will begin a new period of Confinement.

During your hospitalization, the Plan pays Covered Charges for a semi-private Hospital room and for Medically Necessary services and supplies including inpatient anesthesia (outpatient anesthesia is paid as a non-basic benefit). The services must be provided by an employee of the Facility. The Facility must bill for the services and it must retain the money collected for the service.

Some examples of non-covered services include the following:

- Private duty nurses;
- Private room, unless Medically Necessary (if not Medically Necessary, you will have to pay the difference between the cost of the private room and the semi-private room);
- Non-medical items, such as television and telephone;
- Medications, supplies, and equipment you take home from the hospital; and;
- Custodial care.

Inpatient Care in a Skilled Nursing Facility (SNF). The Plan pays for inpatient Skilled Care at the Medicare reimbursement rate for the first 20 days of inpatient stay regardless of whether the care is provided at a Skilled Nursing Facility, a Hospital, or any other Facility listed in Section 2 (Definitions). This includes payment for nursing care, drugs, physical therapy, occupational therapy and speech therapy provided by the Skilled Nursing or other Facility, and any other service that would be covered if the person was an inpatient in a Hospital. If the Covered Person is eligible for Medicare and this Plan would therefore be secondary to Medicare, the Covered Person will be responsible for any charges billed by the Facility that are over and above the Medicare reimbursement rate. This is true if the Covered Person has not actually enrolled in Medicare.

To be considered a Covered Expense, the Confinement must be recommended by a physician who certifies that 24-hour skilled nursing care is Medically Necessary as an alternative to hospitalization. Coverage will be provided for 100 days. The first 20 of the 100 days will be paid in full. After that, you will be required to contribute toward the cost of care in an amount equal to the Medicare co-payment rate in effect at the time. In addition, to qualify for Skilled Nursing benefits, you must have been confined to a Hospital for at least three days, and enter the Skilled Nursing Facility within 14 days following your discharge from a Hospital. No benefits will be paid for care we determine to be Custodial Care. Skilled nursing care must be approved by the Case Management Consultant.

Inpatient Mental Health Care. The Plan pays for hospitalization for acute mental health care for up to 120 days of inpatient care per Confinement. (If the patient is suffering from a biologically based mental illness or is a child with serious emotional disturbances – see paragraph below). Another 120 days becomes available each time you are out of the Hospital for 90 days. Thirty additional days of hospitalization are covered as a non-basic benefit subject to deductible and co-payment.

Timothy's Law requires that if a patient is suffering from a "biologically based mental illness" as defined in this document, or if the patient is a "child with serious emotional disturbances as defined in this document, the inpatient hospital benefit will be the same as any other illness. However, the claim will be subject at all times to review and/or retrospective denial by the plan's case management consultant. Call the Plan's case management consultant in advance if you want further information on whether your claims will be approved or denied. Appeals to a denial of benefits under this section are explained in Section 9 of this document.

Inpatient Care for Alcohol or Chemical Abuse. The Plan pays for inpatient hospitalization for treatment of alcohol and substance abuse in a Facility certified by the State of New York Office of Alcoholism and Substance Abuse Services, or (if

provided out-of-state) a Facility approved by the Joint Commission on Accreditation of Healthcare Organizations to provide a chemical abuse treatment program. Benefits are subject to deductible and co-payment and are limited to 28 days of hospitalization per calendar year and 42 days per lifetime per Covered Person.

Ambulance Service and Pre-Hospital Emergency Services. The Plan provides coverage Emergency Medical Treatment as the term in defined in Section 2 of this Plan as long as such services are provided by an ambulance service certified under the Public Health Law. We will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service in cases where 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.

In addition to the services described above, we will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

A. Ground or air ambulance service for an urgent condition. When you have an urgent condition the need for care is less than the need for care in 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. Air ambulance service for an emergency condition, and

C. Transportation between facilities.

Air ambulance transportation requires approval from the case management consultant before you receive the transportation, or the payment may be denied retrospectively because it is not considered Medically Necessary.

Hospice Care. The Plan pays for hospice care during a terminal Illness if a person has been certified by their primary care physician as having a le expectancy of six months or less, and if care is provided by a hospice organization that has an operating certificate issued by the New York State Department of Health or, if provided in another State, the agency must be approved for hospice services in that State or by Medicare.

The Plan pays Covered Charges for medical care provided by a physician, and bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed for up to 210 days, as well as day care services provided by the hospice organization, and five days of bereavement counseling services. Home care and outpatient services must be billed through the hospice organization.

Outpatient Care. The Plan pays the following benefits for Medically Necessary outpatient services and supplies (including anesthesia), provided the service is provided by an employee of the Facility, the Facility bills for the service, and retains the money collected for the service:

- **Surgical Procedures** performed in a Hospital or other facility, ambulatory surgery center or physician’s office.

  If a Covered Person is receiving benefits from this Plan in connection with a mastectomy, the Plan will pay for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prosthesis and treatment of the physical complications of all

stages of mastectomy, including lymphedema, as recommended by the physician in consultation with the patient.

- **Emergency Medical Treatment for an injury or illness.** (An illness or Injury is considered emergent if failure to render immediate care could result in loss of life or impairment of bodily function.) Non-emergency treatment in a Hospital emergency department or urgent care center may be covered as a non-basic benefit.
- **Pre-admission Tests, including x-rays.** The tests must be for diagnostic purposes and be done in connection with the illness or injury which required surgery. The surgery must be requested by a physician before the tests are taken and the tests must be those that would have been covered if done as an inpatient.
- **Diagnostic Procedures, including x-rays, CT scans, MRI's, laboratory tests and allergy testing.** The procedures must be related to and necessary for the diagnosis of an illness or injury, ordered by a physician, and billed by a Facility or physician's office. The Plan also pays for physician Interpretation of these tests. Allergy injections and serum s are covered as a non-basic benefit.
- **Radiation Therapy, Including use of isotopes for therapeutic or diagnostic purposes, and non- experimental, non-investigational chemotherapy.** (The Plan will cover experimental and investigational services only if so directed by a state certified external appeal agent.)
- **Physical Therapy after related surgery or hospitalization.** The Plan Covered Charges for treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio- mechanical and neurophysiological principals. Also covered are devices to relieve pain and restore maximum function to prevent disability following illness, injury, or loss of body part. Physical therapy treatment must be prescribed by a Physician and be provided by a Professional Provider. In addition, the treatments must begin no later than six months following discharge from the Hospital or the date of outpatient surgery, and be completed within 12 months from the date of discharge or outpatient surgery. There must be an expectation that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. If these criteria are not met, payment for 20 additional visits may be considered as a non-basic benefit subject to deductible and co-payment.
- **Speech Therapy.** The Plan pays for speech therapy provided such therapy (1) is prescribed by a Physician; (2) is active treatment for a medical condition resulting in a functional defect, or to restore speech, or to correct a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes; (3) Is expected to result in practical improvement in the level of function within a reasonable period of time; and (4) is performed by a licensed speech therapist, licensed speech language pathologist or otherwise certified speech therapist. A periodic review of improvement levels will be performed. Coverage will continue until the patient is able to be understood verbally or it is recognized that verbal understanding is not possible. In order to be covered as a Basic Benefit, the therapy must be in connection with a condition for which the Covered Person has been hospitalized, or in connection with surgical care. Additional coverage for up to 20 visits may be available as a non-basic benefit.

- **Occupational Therapy.** The Plan pays Covered Charges for treatment of a physically disabled person by means of constructive activities designed and adopted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living, as well as those required by a person's particular occupation. The services must be prescribed by a Physician, performed by a Professional Provider, and billed by an approved Facility. There must be expectation that the therapy will result in practical improvement in the patient's level of functioning within a reasonable period of time. Occupational therapy supplies are not covered.

  In order to be covered as a Basic Benefit, the therapy must be in connection with a condition for which the Covered Person has been hospitalized, or in connection with surgical care. In addition, the treatment must begin

no later than six months and within 12 months of the date of Hospital discharge or surgery. Otherwise, payment for up to 20 visits may be made as a non-basic benefit, subject to deductible and co-payment.

- **Kidney Dialysis for acute or chronic kidney disease.** If you are eligible for Medicare, the benefit paid will be reduced by the amount of benefit you are eligible to receive from Medicare, whether or not you are actually enrolled.
- **Second Medical and Surgical Opinions.** The Plan pays for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment.

The Plan will also pay for a second surgical opinion by an appropriate physician to consider the surgical procedure being recommended. Benefits will be paid as Basic benefits only if the specialist who gives the second opinion does not perform the actual surgery and is not part of the same medical group as the treating surgeon. If the specialist who gives the second opinion performs the surgery, the benefit will be paid as a non-basic benefit, subject to deductible and co- payment. Required tests and x-rays ordered by the consulting physician as part of the second opinion will also be covered. If the first two physicians disagree on the need for surgery, the Plan will pay for a third opinion.

Benefits will not be paid for second opinions in connection with medical, cosmetic or dental surgical procedures not otherwise covered under the Plan; minor surgical procedures that are routinely performed in a Physician's office such as incision and drainage for abscess or excision of benign lesions; a second surgical opinion obtained more than six months after a physician or surgeon first recommended the surgical procedure; an opinion rendered by the physician who performs the surgical procedure; an opinion given while the Covered Person is hospitalized as an inpatient; childbirth (other than another caesarean section following an initial caesarean section) or elective abortion; surgery involving local Infiltration anesthesia; sterilization; an injury due to employment with any Employer or from self-employment; or surgery already performed, except In the case of a covered reversible surgical procedure.

Routine Screening and Examinations, Immunizations and Preventive Care.

- **Breast Cancer (Mammography).** The Plan pays for screening for occult breast cancer on an annual basis for women age 40 and older, as well as a single baseline mammogram for women age 30 to 39 years old. Also covered are screening mammograms at any age for women at risk who have a prior history of breast cancer or a first degree relative with a prior history of breast cancer. The screening may be provided in the outpatient department of a Facility or in a Professional Provider's office.

- **Cervical Cancer (Pap Smears).** The Plan pays for screening for cervical cancer and its precursor states for women covered under the Plan. Cervical cytology screening includes pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Benefits are limited to payment for one screening per year. The Plan pays the first $75 of charges for routine annual gynecology office visits as a Basic Benefit, and the balance as a Non-Basic Benefit, subject to deductible and co-payment.

- **Osteoporosis (Bone Mineral Density Measurement and Testing).** The Plan pays charges for bone mineral

density measurement and testing, as well as drugs and devices to treat the condition. To qualify for this benefit, the person must meet either the eligibility criteria under the Medicare program or those set by the National Institute for Health (NIH) for the detection of osteoporosis. The law provides that individuals qualifying for coverage shall, at a minimum, include Individuals having any of the following conditions:

A previous diagnosis of or a family history of osteoporosis; or
Symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
A prescribed drug regimen posing a significant risk of osteoporosis; or
Lifestyle factors posing a significant risk of osteoporosis; or age, gender, and/or physiological characteristics which pose a significant risk of osteoporosis.

- **Prostate Cancer (PSA Testing).** The Plan pays charges for prostate cancer screening for men over age 50, limited to one screening annually. Benefits for an annual screening are also provided to men over 40, if they have a family history of prostate cancer or other prostate cancer risk factors, or at any age if they have a previous history of prostate cancer. A standard diagnostic exam (screening) includes a digital rectal exam and prostate-specific antigen (PSA) test.

- **Colon Cancer (Colonoscopy).** The Plan pays for one routine colon cancer screening (colonoscopy) per Covered Person age 50 or older every five years, or when the only reason given for the procedure is ''family history."

  Family is defined for purposes of this section as mother, father, child, brother, sister, aunt, uncle, or grandparent.

- **Routine Physical Exams (Adult Wellness Benefit).** The Plan pays for an annual physical examination for Covered Persons age 19 and older. Physical examinations which include a routine eye examination by an ophthalmologist or optometrist (not including refractions), and/or routine hearing examinations performed by a physician are counted toward the maximum benefit. Routine injections, such as for travel, are covered under this benefit as well.

- **Routine Eye Examinations for Dependent Children up to Age 19.** The Plan pays for one routine eye examination for dependent children under the age of 19 once in every 24 month period. The maximum benefit is $100.00 per examination. Examinations and evaluations related to refractions are not covered.

- **HPV Vaccinations.** The Plan will pay for HPV (cervical cancer) immunizations for covered Employees and/or Dependents up to the age of 26, once in a Covered Person's lifetime.

- **Immunizations and Preventive Care.** In addition to the tests and screenings specifically described, the Plan pays for any preventive care that is rated "A" or "B" from the United States Preventive Services Task Force. It also pays for immunizations pursuant to the Advisory Committee on Immunization Practices, as well as for other preventive care and screening that are included in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Well Child Care. The Plan pays Professional Provider charges for well child visits and immunizations in accordance with the prevailing standards of the Advisory Committee on Immunization Practices (ACOP), including one (initial) Hospital checkup at birth, as well as well-child immunizations as determined by the Superintendent of Insurance in consultation with the New York State Commissioner of Health.

Services covered as part of a well child visit include taking complete medical histories; performing a complete physical exam; performing developmental assessments; giving anticipatory guidance; performing laboratory

tests; giving appropriate immunizations; and/or providing other services ordered at the time of the well child visit.

Maternity Care. The Plan pays Covered Charges for inpatient Hospital care for the mother and infant for at least 48 hours following a normal delivery and at least 96 hours following a caesarian delivery, regardless of whether such care is Medically Necessary. In the event the mother elects to leave the Facility before the end of the minimum stay, the Plan will pay for one home care visit at the mother's request. This visit does not count toward the home care limit explained elsewhere in this document, and will not be subject to a deductible or co-payment.

Care provided as a patient in a Facility includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan also provides coverage for complications of pregnancy and for anesthesia during delivery. It does not, however, pay for elective termination of pregnancy.

"Complications of pregnancy'' are conditions that require Hospital admission (not including terminations of pregnancy). The diagnosis must be one that is distinct from pregnancy but which is adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Non-elective caesarian section, termination due to ectopic pregnancy, or early spontaneous termination of pregnancy are also considered "complication of pregnancy." The following conditions would not be considered "complications of pregnancy'': false labor; occasional spotting; physician-prescribed rest during pregnancy; morning sickness; pernicious vomiting of pregnancy; toxemia; and similar conditions associated with the management of a difficult pregnancy.

The Plan pays physician charges for maternity care beginning with the first visit in which pregnancy is determined. It includes all prenatal and postpartum care, including services of a licensed midwife, practicing under qualified medical direction, and affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law. Physician charges for maternity care, including complications of pregnancy, are paid as a non-basic benefit, subject to deductible and co-payment.

Sleep Disorder Testing. The Plan pays Covered Charges for diagnostic testing for sleep disorders provided that the Facility where such care is provided is accredited by the Association of Sleep Disorder Centers (or is in a contractual preceptor relationship with an accredited Facility) and Is under the direction and control of a physician. The Covered Person must be referred by the attending Physician. The need for diagnostic sleep testing must be confirmed by medical evidence, and the Covered Person must have symptoms of either narcolepsy or severe upper airway apnea.

Contraceptive Devices. The Plan pays for any agent or device intended to prevent conception. Oral contraceptives are covered under the Prescription Drug benefit and are subject to prescription drug co-payments.

NON-BASIC PLAN BENEFITS

SCHEDULE OF NON-BASIC PLAN BENEFITS AND LIMITATIONS

Non-Basic Benefits. If you have a medical expense that Is not covered under the Basic Plan, it may be covered as a non-basic benefit, subject to deductible and co-payment (see below). Certain benefits must be certified by the case management consultant in order to confirm coverage, please call 607-648-3400 or 800-541-7403 to speak with a case

manager.

Deductible. The portion of your bill that you pay before the Plan begins to pay for non-basic expenses is called the non-basic "deductible." Each Employer determines the deductible for its Employees. However, as an example, you may have a deductible of $75.00 per Covered Person per calendar year. If so, and you have several covered Dependents, the maximum deductible for all covered members of your family, regardless of its size, would be three times the individual deductible, or $225.00 per calendar year.

Deductible Carryover. Covered expenses incurred and credited toward the non-basic deductible during the calendar months of October, November, and December will be applied toward the deductible for the next calendar year.

Common Accident Provision. If two or more Covered Persons in the same family are injured in the same accident, only one deductible will be applied. The single deductible will apply to all Covered Expenses incurred by them as a result of the accident during the then current calendar year.

Co-payment. After you meet the non-basic deductible, the Plan will pay 80% of the next $2,000 in eligible expenses, up to a maximum Plan payment of $1,600. The Covered Person must pay 20% of the $2,000 or $400. After the covered Person has paid $400, the Plan will pay 100% of the Covered Charges.

Any amounts paid by you for out-patient mental health treatment or home health care will not count toward your out-of-pocket maximum, but will remain subject to the benefit limitations shown below, In addition to deductible and co-payment requirements.

In cases where an alternative procedure, service or Medically Necessary treatment can be performed to properly treat an illness or injury, the Plan may provide coverage if the alternative treatment is more cost- effective or medically sound, even if the alternative treatment is not a Covered Benefit under the Plan. Decisions about alternative treatment will be authorized by the Plan Administrator in consultation with the case management consultant and the patient.

Inpatient Care in a Hospital. The Plan pays Covered Charges in excess of the benefits provided under the Basic Plan for expenses resulting from inpatient Confinement in a Hospital. (This benefit does not cover additional days of inpatient treatment related to inpatient treatment of mental or nervous disorders, or inpatient treatment of alcoholism, alcohol and/or substance abuse.) **Pre-certification of hospitalization by the case management consultant is requested.**

Outpatient Facility Charges. Outpatient services not covered by the Basic Plan that are rendered in a Facility, physician's office or clinic, and billed by the entity rendering treatment are covered as non-basic benefits if the service is covered under the Plan.

Physician Services for Medical and Surgical Care. The Plan pays for services of a physician for non-- cosmetic surgical care and medical care and treatment in a Facility, a home, or a physician's office providing that the physician who performs the service bills for the service and the services are performed in connection with a Covered Person's Illness or injury.

When more than one surgical procedure is performed during an operation, the Covered Charge for the secondary procedure will be paid at not more than 50% of the charge normally paid for the procedure. The Covered Charge for an assistant surgeon is limited to 20% of the primary surgeon's Covered Charge, and 13% of the surgeon's Covered Charge for a physician assistant during surgery. There is no coverage for incidental procedures.

Organ or Tissue Transplants. The Plan pays Covered Charges for hospitalization for transplants as a basic benefit. Other

transplant-related charges are paid as a non-basic benefit. The Plan pays for treatment and services or supplies related to transplants, subject to the following conditions:

The Covered Person who is the organ or tissue recipient must receive two opinions attesting to the need for the transplant surgery. The opinions must be in writing by Board-certified specialists in the involved medical specialty. The specialists must certify that alternative procedures, services or courses of treatment would be ineffective in the treatment of the Covered Person's condition.

Treatments, procedures, services and/or supplies must be established clinical practices that are not Experimental and/or Investigational (as defined in this Plan).

Hospital and medical expenses incurred by the organ donor will be considered Covered Expenses of the Covered Person who is the recipient provided that the organ or tissue transplant actually occurs, and the donor does not have medical benefits that cover donor expenses related to the transplant.

The Hospital in which the procedure is performed must be Medicare-approved for reimbursement of that particular transplantation therapy.

The Plan does not pay for costs related to searches or screening for donors.

Contact the Case Management Consultant for pre-certification of transplant procedures.

Home Health Care. The Plan will provide coverage for home health care provided by a certified or licensed Home Health Care Agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. If you receive home health care outside of New York State, a Home Health Care Agency must have Medicare approval as well as an appropriate operating certificate to provide home care issued by the appropriate state agency.

The Plan will pay for 40 visits in a calendar year, subject first to your $50.00 deductible, then your payment of 25% of allowed charges in excess of $50.00 deductible. These amounts do not count toward your out-of-pocket maximum deductible or co-payment.

Coverage for home care will be provided if (a) a home care treatment plan is established and approved in writing by a Professional Provider; (b) provided by a certified or licensed agency; (c) you apply through your Professional Provider to the agency with supporting evidence of your need and eligibility for home care, and (d) the home care is related to an illness or injury for which you would have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a skilled or acute level of care. The Plan does not pay for custodial care or non-medically necessary care. Each visit by a member of a home health care team is considered a separate home health care visit, and four hours of home health aide services are considered as one home health care visit.

Home health care consists of one or more of the following:

- part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- part-time or intermittent home health aide services that consist of primarily rendering direct care to you;
- physical, occupational or speech therapy if provided by the agency;

- medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of the agency to the extent such items would have been covered if the person had been confined in a Hospital or Skilled Nursing Facility.

Outpatient Mental Health Care. The Plan pays Covered Charges for outpatient mental health visits to a Professional Provider. In addition, the Plan will pay for three outpatient crisis intervention (emergency visits) per calendar year paid in the same manner as other medical emergency visits. Covered Expenses include therapy sessions, electroshock therapy and psychological testing.

Timothy's Law requires that if a patient is suffering from a "biologically based mental illness" as defined in this document, or if the patient is a "child with serious emotional disturbances" as defined in this document, the outpatient mental health care benefit will not apply and the benefit will be the same as office visits to any other provider. However, the claim will be subject at all times to review and/or retrospective denial by the plan's case management consultant. Call the Plan's case management consultant in advance if you want further information on whether your claim will be approved or denied.

Outpatient Care for Alcoholism and Chemical Dependency. The Plan pays for outpatient visits in an approved Facility for the diagnosis and treatment of chemical dependence. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. There is no coverage for visits that consist primarily of participation in programs of a social, recreational or companionship nature. Services will be covered only if they are provided by an employee of the Facility. Payments will be made only to Facilities, not to a person who provides services, nor to a Facility that turns payment over to a person who provides services.

Coverage is provided for up to an aggregate of 60 outpatient visits per Covered Person in each calendar year, up to 20 of which may be used for family therapy. Family therapy consists of visits that help family members understand the affected person's illness and play a meaningful role in the person's recovery. Coverage of family therapy will be provided even if the person needing treatment is not receiving the same. Each family therapy session will be counted as a separate visit regardless of how many family members attend the therapy. The family therapy visits may be used only by those persons covered under this Plan. Services are subject to review by the case management consultant, both concurrently and retrospectively.

Chiropractic. The Plan pays for services rendered in connection with the detection or correction by manual or mechanical manipulation, 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. The care must be rendered by a provider licensed to provide such services and must be Medically Necessary. The case management consultant will periodically review chiropractic care to determine whether II continues to be Medically Necessary, and benefits will be denied if the case management consultant determines it is no longer Medically Necessary treatment. Maintenance care is not covered.

Podiatry. The Plan pays Covered Charges for services of a Professional Provider for treatment of conditions affecting the foot. Medical treatment of chronic foot conditions (as opposed to treatment of acute injury) would be subject to deductible and co-payment. Chronic conditions of the foot include but are not limited to bunions, plantar fasciitis, heel spurs, stress fractures, neuromas, flat feet, fallen arches and any imbalance of instability of the foot. Examination, diagnosis and treatment of corns, calluses or toenails, including their cutting or removal is covered only if treatment is prescribed by a physician for a metabolic disease, such as diabetes mellitus or a peripheral vascular disease, such as arteriosclerosis. Routine Care of the feet, as defined in Section 2, is not covered.

Durable Medical Equipment. The Plan pays Covered Charges for rental, repair or maintenance of durable medical equipment, as well as supplies for use with the equipment, subject to payment of deductible and co-payment, when such equipment and supplies are determined to be Medically Necessary. The Plan may also purchase the equipment, if it determines purchase to be more practical or less expensive than rental. (In no case will the Plan pay more in rental charges than it would have cost to purchase the equipment.) The equipment must be the kind that is generally used for a medical purpose, as opposed to a··Comfort or convenience purpose. Examples of durable medical equipment include crutches, standard wheelchairs, hospital beds, and home dialysis units. If the equipment is purchased and later sold, the proceeds must be paid to the Plan. The Plan will pay for replacement cost of equipment provided (1) the equipment remains Medically Necessary, with or without a change in the Covered Person's condition; and (2) the equipment has fulfilled its anticipated life span as defined by the manufacturer and was subject only to normal wear and tear. Repairs to DME are covered if the DME remains Medically Necessary and as long as the warranty has expired.

The Plan *will not* pay for deluxe equipment (e.g., motor-driven wheelchairs or beds) when standard equipment is available and medically adequate; items such as air cleaners, air conditioners, dehumidifiers, heating pads and hot water bottles; installation charges or delivery and setup charges; materials purchased to construct equipment; or equipment which is available in a Facility where the patient is confined.

Contact your case management consultant for pre-certification for DME costing more than $1,000.00.

Prosthetics. The Plan pays Covered Charges for prosthetic devices and/or orthopedic appliances used to replace functioning natural parts of the body which are determined to be Medically Necessary to relieve or correct a condition caused by an injury or illness. Repairs to and replacement of these devices may also be covered under certain circumstances. Contact your Case Management Consultant for pre-certification for prosthetic devices costing more than $1,000.00, and for information on replacement of prosthetics or orthopedic appliances.

A prosthetic device is an artificial organ or body part, including but not limited to, artificial limbs and eyes used to replace functioning natural body parts. Prosthetic devices do not include, for example: eyeglasses, contacts, foot orthotic supports, devices or shoes (unless covered elsewhere in the Plan), hearing aids, medical supplies, certain special articles of clothing or cosmetic devices, wigs, dental prosthesis, dentures or other devices used in connection with the teeth. However, the Plan will pay for necessary dental prostheses resulting from an accidental injury to sound natural teeth within 12 months of the accident, for a first pair of corrective lenses after cataract surgery, mandibular repositioning due to TMJ, and keratonconus. Delivery charges, service charges or extended warranties and sales tax are not covered.

Private Duty Nursing Services. The Plan pays Covered Charges for private duty registered nurses, other than a nurse who ordinarily resides In the Covered Person's home, or who is a member of the Covered Person's immediate family. Expenses incurred for a private licensed practical nurse will be paid on the same basis as for registered nurses if the attending physician certifies that the nursing care is necessary and a registered nurse is not available. Expenses will not be paid, however, for the first 48 hours of such service provided to the Covered Person in any calendar year. Expenses will also not be paid when the patient is confined to a Facility.

The nursing care must be provided by an R.N., an L.P.N., a vocational nurse or a Christian Science nurse, all of whom must be state-licensed and registered. The services must be prescribed by a physician and consistent with the condition being treated. The Plan will not pay for private duty nursing rendered by a home health agency, unless the agency is licensed to provide that type of care in the state where it is operating.

Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy.

- **Physical Therapy.** The Plan pays for physical therapy when not covered by the Basic Plan, limited to 20 visits per Covered Person per calendar year.
- **Speech Therapy.** The Plan pays for speech therapy when not covered by the Basic Plan, limited to 20 visits per Covered Person per calendar year.
- **Occupational Therapy.** The Plan pays for occupational therapy when not covered by the Basic Plan limited to 20 visits per Covered Person per calendar year.
- **Respiratory Therapy.** The Plan pays Covered Charges for the introduction of drugs or moist gases into the lungs when performed by a Professional Provider for treatment of breathing problems resulting from an Illness or Injury, limited to 20 visits per Covered Person per calendar year.

Cardiac Rehabilitation. The Plan pays Covered Charges for cardiac rehabilitation programs when Medically Necessary and prescribed by a physician, subject to deductible and co-payment requirements. The therapy must be performed by a Professional Provider. To be eligible for cardiac rehabilitation program, a Covered Person must have had either a documented diagnosis of acute myocardial infarction within the preceding 12 months, coronary bypass surgery, or a diagnosis of stable angina pectoris.

Additional Medical Services and Supplies. The Plan will pay for the following services when not covered through the Basic Plan:

- Anesthesia Services. The Plan pays for administration of necessary anesthesia and related procedures in connection with a covered surgical service. A Professional Provider other than the Professional Provider performing the surgery or the surgical assistant must do the administration and related procedures. The Plan will not cover the administration of anesthesia for a procedure not covered by the Plan;
- Oxygen and its administration;
- Blood Transfusion, including blood or blood plasma if they are not available free of charge in the local area.

Diabetes Management, Supplies, and Treatment. The Plan pays Covered Charges for the following equipment and supplies for the treatment of diabetes, when they are Medically Necessary and are prescribed by a Professional Provider who is legally authorized to prescribe under Title 8 of the New York Education Law:

Insulin and oral agents for controlling blood sugar (through the prescription drug program); Blood glucose monitors and blood glucose monitors for the visually impaired; Data management systems; Cartridges for the visually impaired; Test strips for glucose monitors, visual reading and urine testing; Injection aids; Insulin pumps and accessories; Insulin infusion devices; and additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Repair, replacement or 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 pays for disposable syringes and needles used solely for injection of insulin (but not for multi-use disposable syringes or needles). The Plan will also pay for diabetes self-management programs provided by a Professional Provider or their staff in connection with Medically Necessary visits when you have been diagnosed with diabetes, when there has been a significant change in your symptoms, when you experience the onset of a condition requiring changes in self-management, or when re-education is Medically Necessary. Education may be provided by a certified diabetes nurse educator, nutritionist, dietician or other provider as required by law. Education must be provided in a group setting, wherever possible, unless home visits are Medically Necessary.

Treatment of Infertility. We will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility, subject to the conditions explained below. Please note that any limitations placed on coverage apply only to the benefits added by Chapter 82 of the Laws of 2002.

Infertility Defined. For the purpose of this paragraph, infertility has the meaning set forth in the standards and guidelines established and adopted by the American Society for Reproductive Medicine and the regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.

Coverage Provided for Individuals 21 to 44 Years of Age. The benefits provided by this paragraph are available only to Covered Persons who are between the ages of 21 and 44 as of the date the services are rendered.

Coverage Only Provided for Appropriate Candidates. Coverage under this paragraph will only be provided to appropriate candidates, within the age group described above. An appropriate candidate is determined by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

Covered Services. Subject to the other provisions of this paragraph and your Plan, we will provide benefits under this paragraph for:

Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D&C"), that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and procedures necessary to determine infertility or in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are hysterosalpingogram; hysteroscopy; endometrial biopsy; laparoscopy; sene-hysterogram; post-coital tests; testis biopsy; semen analysis; blood tests; ultrasound; and other Medically Necessary diagnostic tests and procedures, unless excluded by law.

Plan of Care Required - All services covered under this paragraph must be prescribed by a physician as part of an overall "plan of care." The plan of care must be in writing, and must be available for review by us. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.

Services must be received from Eligible Providers. Services covered by this paragraph must be received from “Eligible Providers" as determined by us In accordance with applicable regulations of the New York State Insurance Department. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine.

Excluded Services. We will not pay benefits for any services related to or in connection with:

- In-vitro fertilization,
- Gamete intra-fallopian transfer (GIFT);
- Zygote intra-fallopian transfer (ZIFT);
- Sex change procedures;
- Cloning;
- Sperm banking and donor fees associated with artificial insemination or other procedures;
- Other procedures or categories of procedures excluded by statute.

Experimental Procedures Are Not Covered. This benefit does not cover services or procedures that are Experimental according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental, in accordance with Section 9 of the Plan.

PRESCRIPTION DRUG BENEFITS

What Is Covered? The Plan covers drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend: "Caution - Federal Law prohibits dispensing without a prescription." The drug or medication must be prescribed by a Professional Provider, and approved by the FDA for the treatment or for specific diagnosis or condition. The drug must also be Medically Necessary treatment of the condition for which the drug is prescribed, and not Experimental and Investigational as defined in this Plan, unless otherwise required pursuant to an external appeal. Insulin and oral agents for controlling blood sugar are also provided through the prescription drug program. Oral Contraceptive drugs are also covered under this Plan under the Prescription Drug benefit. However, contraceptive devices are covered as a Basic benefit.

Prescription Drugs include Medically Necessary enteral formulas for which a 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 those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. The Plan also pays for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to a written order. However, coverage for modified solid food products is limited to $2,500 in a calendar year or any contiguous period of 12 months.

Generic equivalents of prescribed drugs will be provided unless specifically prohibited by the prescribing physician. If you choose to obtain a brand name drug when a generic equivalent is available, you will be responsible to pay the excess charges.

What is not covered? In addition to any exclusions found elsewhere in this Plan, benefits are not provided under the Prescription Drug Plan for the following:

- Drugs that do not require a written prescription (except insulin);
- Drugs that have over-the-counter non-prescription equivalents, except as otherwise provided in the Plan

(non-prescription equivalents are drugs available without a prescription that contain the same active ingredient as their prescription counterparts. If it is Medically Necessary for the person to use the specific over-the-counter equivalent drug, it will be covered by the Plan;

- Artificial appliances, therapeutic devices, hypodermic needles and similar devices, even though a prescription may be required to obtain;
- Administration or injection of drugs;
- Appetite suppressants;
- Vitamins or any herbal products (except those that by law require a prescription);
- Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of drugs that we often determine to be not Medically Necessary include those prescribed or dispensed for hair growth stimulants or removing wrinkles;
- Injectable drugs (other than those that are self-administered);
- Blood or blood plasma;
- Drugs dispensed to patients in Facilities, unless the Institution does not include services for drugs;
- Drugs for which payment is available under Federal or State law, such as Workers' Compensation or no-fault insurance, even if you have not made a timely claim for benefits, or you fail to appear for a required hearing;
- Drugs that are determined to be Experimental or Investigational (unless otherwise required to be covered pursuant to external review); and
- Fertility drugs relating to the following infertility services: in vitro fertilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); sex change procedures; cloning, and other procedures or categories of procedures excluded by statute.

How Is Your Co-payment Determined? Your drug co-payment, if any, is determined by your collective bargaining agreement. Depending upon the program in which the Employer participates, the co-payment may be less for generic drugs. Contact your Employer's Plan Representative for co-payment information.

Where to Obtain Prescription Drugs. If you obtain your insulin or prescription drugs at a "participating pharmacy" you will pay only your co-payment or the cost of the drug, whichever is less. (You must present your identification card at the time of purchase in order to be fully reimbursed.) If you obtain your drugs from a pharmacy that does not have an agreement with this Plan (a "non-participating pharmacy"), you must pay for the drugs at the time of purchase and fill out a claim form to obtain reimbursement. You may not receive full reimbursement for the cost of drugs obtained at non-participating pharmacies.

At non-participating pharmacies, the Plan will pay the lesser of the average wholesale cost of the drug to the pharmacy where the prescription was filled, plus any dispensing fee paid by the Plan to participating pharmacies in that community (or the nearest community where there are participating pharmacies), less the applicable co-payment; or

the non-participating pharmacy's actual charge, less the applicable co- payment.

Quantity Limits on Drugs and Refills. Normally, you may not receive more than a 35-day supply of any prescription drug. However, "maintenance" drugs (those which must be taken for 35 days or longer) may be obtained in 90-day supplies through the mall order pharmacy. Refills may be obtained for one year from the date of the original prescription, unless otherwise limited by law. Forms that must be filled out for the mail order pharmacy may be obtained from your employer, or from the CASEBP office. Directions for filling out and mailing are contained on the form. Once you have ordered a drug through the mail order pharmacy, re-order forms will automatically be provided when you receive your prescription.

SECTION 6

EXCLUDED CHARGES AND LIMITATIONS

A. Exclusion for Pre-Existing Medical Conditions.

Definition of Pre-Existing Condition and Related Terms.

A **pre-existing condition** is defined as an injury, disease, illness or medical condition for which medical advice, diagnosis, care or treatment was recommended or received in the six-month period immediately preceding the Covered Person's enrollment date. A pre-existing condition also includes any condition which is related to the injury or illness.

Enrollment date is the first day the person becomes covered under the Plan. However, if you are subject to a waiting period before your coverage begins, the enrollment date refers to the first day of the waiting period.

Creditable coverage refers to prior medical coverage, which a Covered Person may have had under a group health plan (including governmental or church plans), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored program such as TRICARE (formerly CHAMPUS), a program of the Indian Health Service, a state high risk pool, the Federal Employee's Health Benefit Program, a public health plan established by a state or local government, a health benefit plan provided for Peace Corps members, or any other health coverage included in the definition of creditable coverage under federal law.

What is a Pre-existing Condition Exclusion? If you have a pre-existing condition at the time you enroll in the Plan, medical expenses incurred for treatment of that condition will not be paid by the Plan until after you have been enrolled in the Plan for 12 full months. If you are a late enrollee in the Plan (that is, you did not enroll in the Plan on the first day you were eligible to do so), the exclusion for pre-existing conditions is 18, rather than 12 months.

Obtaining Credit for Past Medical Coverage. The 12- or 18-month exclusionary period described above may be shortened if you have prior "creditable coverage." Creditable coverage is like a bank account of days you may use to offset the number of days that a pre-existing condition exclusion would otherwise be in force. You will receive credit for your previous coverage as long as there was not a break in that coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited toward a pre-existing exclusion period.

Exceptions to the Pre-Existing Condition Exclusions. The pre-existing condition exclusion rules above don't apply to the following conditions or situations:

(a) Pregnancy is not considered a pre-existing condition.

(b) Dependent newborn children, adopted children under age 18, or children under age 18 who are placed with the Employee for adoption are not subject to an exclusion, provided the Dependent child becomes covered under this Plan or any other creditable coverage within 60 days of his birth, adoption, or placement for adoption, and also provided the child has not had a significant break in creditable coverage (63 or more consecutive days).

(c) Employees or Dependents who have resumed coverage immediately following return from either an absence pursuant to the Family Medical Leave Act, or a period of duty in the military or other Uniformed Services, (unless the illness or injury was incurred or aggravated during the person's performance of that service) are not subject to the pre-existing condition exclusion.

(d) Genetic information indicating a predisposition toward an inherited disease will not be considered a pre-existing condition, unless there has been an actual diagnosis of the inherited disease during the exclusionary period.

(e) Individuals or dependents of individuals who are eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002, providing they have three or more months of creditable coverage.

(f) Any individual under the age of 19 regardless of prior credible coverage.

B. Additional Benefit Limitations and Exclusions. In addition to any benefit limitations or exclusions described elsewhere in this Plan, we will not provide coverage for any of the following:

Acupuncture/Hypnosis/Biofeedback. We will not provide coverage for any service or care related to acupuncture treatment and acupuncture therapy, hypnosis or biofeedback.

Blood Products. We will not provide coverage for blood donor services or for the cost of blood, blood plasma, other blood products, or blood processing or storage charges when they are available free of charge in the local area. When not free in the area, we will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center or a certified blood bank.

Cosmetic Services. We will not provide coverage for 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 we often determine to be not Medically Necessary include breast enlargement, rhinoplasty and hair transplants.

We will, however provide coverage for services in connection with reconstructive surgery when such service is incident to or follows surgery resulting from trauma, infection, or other disease of the part of the body Involved. We will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Plan which has resulted in a functional physical defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy.

Criminal Behavior. We 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 an illegal act, including driving while under the influence of alcohol or

driving while intoxicated. The Illegal act will be determined by the law of the state where the criminal behavior occurred. We will not pay for treatment mandated by a court as a condition of probation.

Custodial and Maintenance Care. We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. (Custodial Care and Maintenance Care are defined in Section 2.)

Dental Care. Except as set forth below, we will not provide inpatient or outpatient 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 reason that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impacted teeth, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, including mandibular repositioning to treat TMJ. In addition, we will provide benefits for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We will also provide the benefits for service and care that is Medically Necessary for treatment due to a congenital disease or anomaly. For purposes of this paragraph, "congenital" means present at birth.

Developmental Delay. We will not provide coverage for any service or care related to the educational treatment of behavioral disorders together with services for remedial education, including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavior (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a participant whose ability to speak has been lost or impaired to function without that ability, is not covered.

Durable Medical Equipment; Prosthetic Devices; Medical Supplies. We will not provide coverage for any service or care related to:

(a) Disposable supplies (for examples, diapers, sponges, syringes, incontinence pads, reagent strips, and bandages prescribed for one-time use outside of a provider site), except that this exclusion does not apply to diabetic supplies covered elsewhere in the Plan;

(b) Wigs, hair prosthetics, or hair implants (except wigs necessitated by hair loss resulting from chemotherapy);

(c) Custom-made shoes and arch supports; and

(d) The purchase or rental of household fixtures, including elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air 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.

Experimental and Investigational Treatment. Unless otherwise required by law, we 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, in our judgment, the Service is experimental or Investigational. See Section 9 for your right to an external appeal of our determination that a Service is experimental or investigational.

"Experimental or investigational" means that we determine 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, i.e., 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 the Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean it is of proven benefit or appropriate or effective treatment for a particular diagnosis or condition.

In determining whether a Service Is experimental or investigational, we may, in our discretion, 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 State 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, and established medical services or technology cannot be used due to medical reasons.

(e) Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in paragraph (c) above, is possible in standard conditions of medical practice, outside of clinical Investigatory settings.

This exclusion 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 Section 4303 (q) of the New York State Insurance Law.

Free Care. We 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 the 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 brother, sister, mother, father, son or daughter, or the spouse of any of them, we will presume that the service or care would have been furnished without charge.

Government Hospitals. Except as otherwise required by law, we will not provide coverage for any service or care you receive in a hospital or Institution which is owned, operated or maintained by the Veterans Administration (VA) or a

federal, state, or local government, unless the hospital is a Participating Provider. However, we will provide coverage for care covered under this Plan in such a hospital for Emergency Medical Treatment. In this case, we will continue to provide coverage only for as long as emergency care is necessary and it is not possible for you to be transferred to another Facility.

Government Programs. We 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, we will reduce our benefits 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); and
   (2) The Employee's employer maintains or participates in a 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); and
   (2) The Employee's employer maintains or participates in a large group health plan that is required by law to have this Plan pay its benefits before Medicare.

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. We will not reduce this Plan's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Plan.

Military Service-Connected Conditions. We 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.

No-Fault Automobile Insurance. We 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. We 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, we will provide coverage for the services covered under this Plan up to the amount of the Deductible. If your claim for no-fault benefits is denied, you must file for an arbitration hearing if we request you to do so. We 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.

Non-Covered Service. We 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 provider considers the

service or care to be Medically Necessary and appropriate.

Nutritional Therapy. We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary, or that it qualifies as diabetes self-management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

Personal Comfort Services. We 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 the following: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers, beauty and barber services, commodes, exercise equipment, arch supports, foot orthotics, or orthotics used solely for sports.

Prohibited Referral. We 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.

Reproductive Procedures. We will not provide coverage for any service or care related to or in connection with the following: In-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra- fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, and other procedures or categories of procedures excluded by statute, pursuant to Chapter 82 of the Laws of 2002 (New York).

Routine Care of the Feet. Except as otherwise provided in the Plan, we will not cover podiatry services. We will also not cover foot orthotic devices including shoe inserts and moldings unless they are the initial pair, custom-made, and determined to be Medically Necessary by the Plan's case management consultant and they are purchased within the first 90 days following foot surgery.

Self-Help Diagnosis, Training and Treatment. We will not provide coverage for any service or care related to self-care diagnosis, training and treatment for recreational, vocational, employment or educational purposes.

Self-Inflicted Injuries. We will not provide coverage for service or care resulting from self-inflicted Injury, unless caused by a medical condition.

Services Starting Before Coverage Begins. If you are receiving care on the day your coverage under this Plan begins, we will not provide coverage for any service or care you receive:

(a) Prior to the first day of your coverage under this Plan; or

(b) On or after the first day of your coverage under this Plan if that service or care is covered under any other health benefits contract, program or plan.

Sexual Dysfunction. We will not provide coverage for treatment of sexual dysfunction unless Medically Necessary, as determined by the case management consultant.

Skilled Nursing Charges. The Plan will pay for inpatient skilled nursing care at the Medicare reimbursement rate, whether the care is provided at a Skilled Nursing Facility or any other Facility providing the skilled nursing care. If the Covered Person is eligible for Medicare and this Plan would therefore be secondary to Medicare, the Covered Person will be responsible for any charges billed by the Facility that are over and above the Medicare reimbursement rate. This is true even if the Covered Person has not actually enrolled in Medicare.

Smoking Cessation Programs. We will not provide coverage for smoking cessation programs, unless it is determined by

the case management consultant to be Medically Necessary. Contact the case management consultant to see if this service will be a covered benefit. If you do not confirm coverage, your claim may be subject to retrospective denial.

Special Charges. We will not provide coverage for charges billed to you for telephone consultations, missed appointments, 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. It also applies to additional fees charged by physicians or Facilities because care is rendered after hours or on holidays. Clinic Facility fees for use of a treatment room are not covered unless the patient is Medicare-primary.

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

Timothy's Law. The benefits provided pursuant to "Timothy's Law" do not apply to 1) individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services; 2) services solely because such services are ordered by a court; 3) services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

Transsexual Surgery and Related Services. We will not provide coverage for any service or care related or leading up to transsexual surgery, including, but not limited to hospitalizations, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender, even if you have been diagnosed as having gender role or psychosexual orientation problems.

Unlicensed Provider. We 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.

Vision and Hearing Examinations, Therapies and Supplies. Unless otherwise provided for in this Plan, we will not provide coverage for any service or care related to:

(a) Routine eye or hearing examinations for the purpose of prescribing, fitting servicing, or changing eyeglasses, contact lenses or hearing aids; except for initial prescription lenses and frames or contacts after cataract surgery or treatment of kerataconus;

(b) Eyeglasses, lenses, frames, contact lenses or hearing aids;

(c) Vision or hearing therapy, vision training or orthoptics; and

(d) Surgery or medical treatment to correct refractive errors, such as LASIK.

War. We will not provide coverage for any service or care which results from war, whether declared or undeclared, including terrorism or resistance to armed aggression.

Weight Loss Services. We will not provide coverage for any service or care in connection with weight reduction or dietary control, including, but not limited to gastric stapling, gastric by-pass, gastric bubble, or other surgery or service, unless we determine that such care or service is Medically Necessary as a treatment for Morbid Obesity. Medical Necessity determinations are made by the Plan and are subject to appeal and external review.

Workers' Compensation. We will not provide coverage for any service or care for which you receive benefits under a workers' compensation or similar law.

SECTION 7

COORDINATION OF BENEFITS

This section only applies if you, your spouse, or a Dependent is covered both under this Plan as well as under another group health plan or program. Coordination of benefits (COB) means that the coverage provided by this Plan is coordinated with coverage that may be available under the other plan, so that there is no duplication of payment or overpayment.

When You Have Other Health Benefits. When you are covered under this Plan as well as another plan, you have what is known as "primary" and "secondary'' coverage. The primary plan is the one that pays its benefits first. The secondary plan is the one that pays second. When that is the case and you receive a service which would be covered by both plans, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits, if necessary, to cover all or some of your remaining expenses. The following are considered to be health insurance plans for purposes of coordination of benefits:

- Any group or blanket insurance contract, plan or policy, Including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
- Any self-insured or non-insured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
- Any Blue Cross, Blue Shield, or other service type group plan;
- 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
- Medical benefits coverage in group and individual mandatory automobile "no-fault' and traditional ''fault" type contracts.

How We Determine Which Plan Pays First. To decide which plan is primary and pays first, we use the following rules:

- If the other plan does not have a provision similar to this one, then it will be primary;
- If you are covered under one plan as an employee and you are only covered as a dependent under the other plan, the plan which covers you as an employee will be primary; except that if you are retired and covered by Medicare, Medicare will be considered primary to your coverage under this contract unless, as a result of federal law, Medicare is deemed to be secondary. If so, the following rules apply:

    1. The program covering you as a dependent of a person in current employment status pays first;

2. Medicare pays second;
3. the program covering you as a retired employee pays third.

- Subject to the provisions regarding separated or divorced 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 which covered the child 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 rule in the other plan will determine the order of benefits.

  There are specific rules for a child of separated or divorced parents:

  - 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.

  - 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:

    (1) First, the plan of the parent with custody of the child;
    (2) Then, the plan of the spouse of the parent with custody of the child;
    (3) Finally, the plan of the parent not having custody of the child.

- If you are covered by 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.

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

Payment of Benefits When This Plan Is Primary. When we are primary, we will pay benefits covered under this Plan as if there were no COB provision.

Payment of Benefits 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 your expenses for an item of service. However, we will not pay more than we would have paid if we were primary. We count 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. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

Effect on Deductible and Co-payment Obligations. Any expense paid by another plan which is primary to this Plan pursuant to this COB provision, or which is charged against the primary plan's deductible and/or co-payment obligation of the Covered Person, will be counted toward any deductible and/or co-payment obligation of the Covered Person under this Plan, provided the expenses would be covered under this Plan if it was primary.

Coordination of Benefits with Medicare. Except as otherwise provided in this section, Medicare will be primary and this Plan will be secondary.

- **Active Employees Medicare-Eligible Due to Age.** If a covered active Employee (or his Dependent) is eligible for Medicare due to age, this Plan will continue to be primary coverage for that covered Employee or Dependent, provided the Employee remains working actively and the Employee's Employer has 20 or more Employees.

- **Employees & Dependents Medicare-Eligible Due to Disability or End-Stage Renal Disease.** If a Covered Person is eligible for Medicare due to disability or end-stage renal disease (ESRD). This Plan will coordinate its benefits with Medicare as follows:

    1. This Plan will be primary only if (a) the disabled person is an active Employee (or covered Dependent of an active Employee), and at least one Employer participating in this Plan has 100 or more Employees, or (b) the person becomes eligible for Medicare due to end- stage renal disease while an active Employee (or covered Dependent of an active Employee).

    2. This Plan will be primary for the first 30 months of Medicare-eligibility of a covered Employee or his covered Dependent who is eligible for Medicare due to end-stage renal disease. After 30 months, Medicare will become primary for that person.

- **Failure to Enroll In Medicare.** If a Covered Person is eligible for Part A and/or Part B of Medicare, but does not enroll in one or both parts, the benefits payable under this Plan will be reduced by the amount he would have received if he had actually enrolled. A Covered Person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him. It is important to enroll in Medicare as soon as you are eligible, so that you do not lose any benefits the Plan would otherwise pay.

Right to Receive and Release Needed Information. We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We 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. We will not be legally responsible to you or anyone else for releasing or obtaining this Information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

Our Right to Recover Overpayments and Repayment to Other Plans. In some cases, we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document which we deem necessary to help us recover any overpayment.

Payments to Others. We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.

SECTION 8

OTHER PARTY RESPONSBILITY FOR CLAIMS

Other Party Responsibility. If you suffer injuries for which another party or payer may be primarily responsible for the loss or payment of the medical expenses, the Plan has and independent right to file a claim or pursue other legal

remedies from or against the party that caused the loss, or any entity which may be responsible for payment of the medical expenses, to recoup benefits paid by the Plan that were caused by a third party, or for which payment is potentially the responsibility of another party. If you suffer injuries for which another party may be responsible, or incur medical expenses whose payment may be the responsibility of another party, please notify the Claims Administrator. The Plan will determine whether it will bring an action against the potentially responsible party for payment of medical benefits it has provided for your treatment. You will not personally be responsible to repay the Plan for these benefits, but the Plan can file a claim or take action directly against parties which may be potentially responsible for the loss or potentially responsible for payment of the medical expenses.

SECTION 9

CLAIMS FILING, PAYMENT OF BENEFITS, APPEAL & REVIEW, LEGAL PROCEEDINGS

Filing a Claim. It is important to submit claims properly and completely, and as soon as reasonably possible. If you omit needed information, your benefit payments will probably be delayed. Your submission of a claim is an authorization to release medical information to the Plan for Plan administration purposes. Even if you are not sure an expense is covered, you should submit it just to be certain. No claims from you or your provider will be considered for payment if submitted more than 15 months from the date of service.

- Make sure you answer all the questions on the form, and that you sign it. (Your address should be your home address, not your work address.)
- Attach an original itemized statement showing the name of the patient; the date of service, treatment or purchase; the amount charged for each item; and the reason for the treatment (diagnosis or nature of illness or Injury). Separate claim forms should be submitted for each person for whom a claim is being filed.
- Mail the completed claim form (with originals of appropriate bills or statements attached) to the Claims Administrator's office for processing**. Do not send it to the Employer.**

  Catskill Area Schools Employee Benefit Plan
  Claims Administrator
  P.O. Box 383
  Grand Gorge, New York 12434
- Claims for prescription drugs obtained from a non-participating pharmacy must be submitted to the Prescription Drug Program Manager.
- If you are eligible for Medicare, then when you receive the Medicare explanation of what was - and what was not - paid by Medicare, you must send that explanation and a copy of the itemized bill to the Claims Administrator in order to process your claim for the expenses not paid by Medicare.
- If the claim is for charges incurred for Emergency Medical Services, the claim form should provide information as to the date, lime, place and circumstances of the accidental injury or onset of illness.

If you have questions concerning the Plan, the status of your claim or specific claim payment, contact the Claims Administrator at (800) 962-6294 or (607) 588-8917.

Proof of Claim. All events which determine the fact that the Plan is liable for a Covered Expense take place on the date the Covered Expense is incurred, which is when the services are performed or the purchases are made. Written proof of claim should be furnished to the Plan's Claims Administrator on the Plan's forms. The filing of a claim is not a precondition to the Plan's liability for a Covered Expense. However, the Plan needs written proof of loss as soon as

reasonably possible in order to process a claim.

Payment of Benefits. Payment of benefits described in the Plan will be made as determined on the basis of the submission of proof that a Covered Expense, fee or expense has been incurred. Payment of unpaid covered hospital expenses will be sent directly to the hospital. Payment of all other Covered Expenses may be made to the Covered Employee or the Service Provider. Any assignment of benefits to a hospital or a provider of medical services or supplies will not be accepted by, or binding on, the Plan unless approved by the Plan's Claims Administrator.

CLAIMS APPEAL REVIEW PROCEDURES

Utilization Review (UR) Procedures. This section explains our utilization review procedure. Utilization Review (UR) decisions relate to the medical necessity of care, including the appropriateness of the level of care or the provider of care; or the experimental and/or investigation nature of care. UR decisions are made when prior authorization is requested for care (the "prospective review process"), during the course of care (the "concurrent review process) and after care is rendered (the "retrospective review process").

Examples of cases that would be reviewed under UR procedures include our refusal or prior authorization for cases determined not to be medically necessary based on Plan language, or our determination that the treatment you *received is experimental and/or investigational in light of your condition.*

Prior Authorization Process.

a. All requests for prior authorization of care are reviewed to determine medical necessity based on Plan language (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is experimental and/or investigational. The Initial review is performed by a nurse. If a nurse determines that the proposed care in medically necessary and not experimental and/or investigational, the nurse will pre-certify the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational, the nurse will issue a "notice of adverse determination" or a denial. Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal (described below).

b. Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to you within three (3) business days following receipt of all information necessary to make the decision.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to a review of the adverse determination give instructions for initiating standard, expedited, and external appeals and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify what additional documentation or Information may be needed for us to make a Level One internal appeal determination.

d. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one (1) business day of the request for reconsideration in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone or in writing, within three (3) business days from the date of

reconsideration. All of the information described in paragraph 3, above, will be included in this notice.

Concurrent Review Process.

a. When you are receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and experimental and/or investigational nature of services you receive throughout the course of treatment.

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary based on Plan language and not experimental and/or investigational. If so, the nurse will pre-certify the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational, or that further evaluation is needed, the nurse will refer the case to a clinical peer reviewer. Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal processes, explained below.

c. Your provider will be notified of the concurrent review decision by telephone or in writing within 1 business day following our receipt of all information or documentation needed for the review.

d. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will advise you of your right to a review of the adverse determination, give instructions for initiating standard, expedited and external appeals, and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify additional information or documentation needed, if any, for us to make a Level One Internal appeal determination.

e. If prior to making an adverse determination no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider by telephone or in writing within 1 business day from the date of reconsideration. All of the information described above will be included in this notice.

Retrospective Review Process.

a. At our option, a nurse will review retrospectively the medical necessity and the experimental and/or investigational nature of services which are subject to utilization review. If the nurse determinates that care you received was medically necessary and not experimental and/or investigational, the nurse will pre-certify benefits. If the nurse determines that the proposed care is not medically necessary or is experimental and/or investigational, the nurse will issue a notice of an adverse determination. Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal.

b. You, or your authorized designee, and your provider will be notified of the retrospective review determination, in writing, within 30 calendar days from our receipt of all Information or documentation needed for the review.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will advise you of your right to request a review of the adverse determination, give instructions for requesting or initiating standard, expedited and external appeals, and specify that you or your assigned designee may request a copy of the clinical review criteria used by us to make the adverse determination. The notice will also specify additional informational or documentation needed, if any, for us to make a Level One internal appeal determination.

d. The provider who rendered care for which benefits are denied may request a Level One internal appeal of the retrospective adverse determination on your behalf (even if not authorized in writing by you to act as your designee).

REVIEW OF ADVERSE DETERMINATIONS

Request for Level One Internal Appeal.

a. You or your authorized designee and, In a retrospective review case, your health care provider may request a Level One internal appeal of an adverse determination, verbally or in writing, within

60 business days from the date that you receive notice of the adverse determination. (If the notice you received did not specify all information required to conduct a Level One internal appeal, the time period for you to request the review will be extended.) To request a Level One internal appeal verbally, you may call1-800-962-6294 or visit us in person. To submit a written request for Level One internal appeal, you may write to the Coordinator, Health/Dental Insurance at the CASEBP office.

b. The procedure that we will follow in reviewing your case will differ, depending upon the urgency of the case. In most cases, a standard Level One internal appeal, described below, will be appropriate. In "urgent cases," an expedited Level One Internal appeal is described after a standard Level One internal appeal below.

Standard Level One Internal Appeal.

a. We will acknowledge your Level One internal appeal in writing within 5 business days after receiving it. The acknowledgment will advise you of the department (including the address and telephone number) designated to respond to the appeal.

b. When one or more Level One internal appeals are received (for example, you submit an appeal, then your health care provider submits an appeal on your behalf), a single Level One internal appeal will be conducted, if necessary, by a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable possesses a current and valid non-restricted license, certification or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition), who did not make the initial adverse determination and who will complete the review.

c. The clinical peer reviewer will render a determination within 30 calendar days after receipt of all necessary information. Written notice of the determination will be provided to you and any other qualified party who submitted a Level One internal appeal within 2 business days after the determination is made, but in no event later than 30 calendar days after receiving all necessary information. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

d. The notice will include detailed reasons and the clinical rationale for the determination. If the determination is adverse, the notice will describe the procedure for filing a Level Two internal appeal. It will also describe the process for requesting an external appeal of the adverse determination. The external appeal process is described in paragraph "e" below. NOTE: if you submit a Level Two internal appeal, the appeal may take longer than the 45-day timeframe for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of the Level One internal appeal.

Expedited Level One Internal Appeal.

a. For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment; or any other issue with respect to which a provider requests an immediate review), you, your authorized designee, or a provider may request an expedited Level One internal appeal of the initial adverse determination.

b. When a request for an expedited Level One Internal appeal is received, the appeal will be conducted, if necessary, by a clinical peer reviewer who did not render the initial adverse determination. The CASEBP Claims Office will provide reasonable access to the clinical peer reviewer assigned to the appeal within 1 business day following receipt of notice of the request for appeal to ensure that all relevant Information is available to the clinical peer reviewer. You may ask that your provider and the clinical peer reviewer exchange Information by telephone or fax.

c. Within 48 hours of receipt by us of all information needed for the appeal, the clinical peer reviewer will render a determination on the expedited Level One internal appeal. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

d. Notice will be provided to you and the provider by telephone or in writing within 24 hours of the determination. The notice will include all of the information described and be enclosed in a notice of standard Level One internal appeal determination. NOTE: If you request a Level Two internal appeal, it may take longer than the 45-day timeframe for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of the Level One internal appeal.

Level Two Internal Appeal.

a. If after you receive notice of a Level One internal appeal determination you are still not satisfied, you or your authorized designee may submit a Level Two internal appeal verbally or in writing. (You also have an option to apply for an external appeal. See below.) The Level Two internal appeal must be received within 60 business days from the date of the Level One internal appeal determination.

b. We will acknowledge your Level Two internal appeal in writing within 15 calendar days after receiving it. The acknowledgment will advise you of the department (including the address and telephone number) designated to respond to the appeal, and will identify additional information, if any, needed for the Level Two internal appeal.

c. Your case will be reviewed, if necessary, by at least one clinical peer reviewer (defined above) who did not make the prior determination.

d. In "urgent cases" where a delay would significantly increase the risk to your health, we will make a Level Two internal appeal determination and call you within the lesser of 2 business or 72 hours after receiving all information needed for the review. Written notice of the Level Two internal appeal determination will also be provided within 2 business days. In all other cases, we will make a Level Two internal appeal determination within 30 business days after receiving all information needed for the review. Often, notice of the determination will be provided to you within 2 business days after the determination is made, but in no event later than 30 business days after receiving all necessary information.

e. The notice you receive will Include detailed reasons for the Level Two internal appeal determination and, if a clinical matter is involved, the clinical rationale for the determination. The notice will also advise you of the right to apply for an external appeal if the timeframe for applying has not expired by the date of receipt of notice of an adverse determination on the Level Two internal appeal.

EXTERNAL APPEALS

General Information: You have the right to an external appeal of certain coverage determinations made by us or on our behalf. An external appeal is an independent review of a coverage determination by a third party known as an external appeal agent. External appeal agents are certified by New York State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility or health care provider associated with the appeal. In this section, a "requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.

Coverage Determinations Subject to External Appeals. In general you may not request an external appeal unless we have issued a final adverse determination with respect to your request for coverage after our Level One internal appeal (paragraphs b. and c. above). You may ask us to agree to an external appeal even though you have not obtained a final adverse determination after Level One internal appeal; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final determination issued upon completion of our Level One Internal appeal must be based on a determination that the requested service is not medically necessary or that the service is experimental and/or investigational. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

Conditions for External Appeal of Medical Necessity. You may request an external appeal of a final adverse determination of medical necessity that is issued upon completion of Level One Internal appeal if you meet the conditions explained above. The provisions of this subparagraph apply only to external appeal of medical necessity determinations. To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service was not medically necessary.

Conditions for External Appeal of Determinations Involving Experimental and/or Investigational Treatment. This subparagraph governs the external appeal of determinations involving experimental and/or investigational treatment. This subparagraph does not govern determinations involving service provided in clinical trials, explained below.

To request an external appeal under this subparagraph, your attending physician must certify that you have a life threatening or disabling condition or disease. A life threatening condition or disease is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A disabling condition or disease is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, that renders you unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify that standard health services or procedures have been ineffective or would be medically inappropriate in treating your life threatening condition or disease, or that no more beneficial standard treatment exists that is a covered service under the contract.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) that, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life threatening or disabling condition or disease.

If you meet the requirements of this subparagraph and all of the requirements of subparagraph ii, you may request an external appeal.

External Appeal of Determinations Involving Clinical Trials. To request an external appeal under this subparagraph, your attending physician must certify that you have a life threatening or disabling condition or disease as described in subparagraph iv above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

1. The National Institutes of Health (NIH), a NIH cooperative or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
2. An entity that has been identified by the NIH as a qualified non-governmental research entity;
3. An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of outlined above, you may request an external appeal. Information on requesting and External Appeal is provided below:

Effect of the External Appeal Agent's Decision on Coverage. The decision of the Ex1ernal Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the External

Appeal Agent decides in your favor, we will cover the service as follows:

For services denied as not medically necessary, we will treat the service as medically necessary and provide coverage, subject to all other conditions of your coverage.

For services denied as experimental and/or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of your coverage.

For services denied as experimental and/or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under the contract. In addition, this external appeal right does not alter your cost-sharing responsibilities, if any, as otherwise provided for in the contract.

Requesting an External Appeal. If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. If your provider requested the Level One internal appeal of a retrospective adverse determination, we will send your provider a standard provider external appeal request form with the notice of final adverse determination. You or your physician may obtain additional standard request forms at any time by calling the New York State Insurance Department at 1-800-400-8882, or by accessing its website at www.ins.state.ny.us; by calling the New York Department of Health at 1-518-486-6074 or by accessing its website at www.health.state.ny.us, or by calling our Customer Service Department. You must file your request for an external appeal with the New York State Insurance Department within 45 days of receiving a final adverse determination upon completion of Level One Internal appeal, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

A Level Two internal appeal is available as an alternative to external appeal (see above); our Level Two internal appeal is optional. However, whether or not you request a Level Two internal appeal, your application for external appeal must be filed with the New York State Insurance Department within 45 days from your receipt of the notice of final adverse determination upon completion of a Level One internal appeal to be eligible for review by an External Appeal Agent. You may be charged a fee of up to $50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful. If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the New York State Insurance Department or the New York State Department of Health. We urge you, but you are not required, to exhaust all levels of the applicable grievance procedure and/or utilization review procedure before taking any further action with respect to our handling of your case. If you are not satisfied, you may contact the New York State Insurance Department at 1-800-342-3736 at any time during the review process. Upon request, the Claims Office will provide you with the appropriate address for writing to the Insurance Department.

Examinations. The Plan shall have the right and opportunity, through its medical representative, to examine any person when and as often as it may reasonably require during the time a claim is pending under the Plan.

Legal Incompetence. Payments made to the Covered Person or his beneficiaries rather than to a service provider are subject to provisions allowing for payment to someone else where either the Covered Person or his beneficiary is a minor or otherwise not legally competent to give a valid receipt for payment.

When sums may become payable to a minor, said sums shall be paid to the minor's parent or legal guardian. In the

event that sums shall become payable to an incompetent, said sums shall be paid to the incompetent's committee. In the event that a Covered Person dies prior to the date that all benefits are paid hereunder, said sums shall be paid to any of the following living relatives: spouse, child or children, parents, brothers or sisters, or to the executors or administrators of the estate. Payment as made above will release the Plan from any further liability with regard to the sums so paid.

Legal Proceedings, No action at law or in equity shall be brought to recover under this Plan of benefits prior to the expiration of 60 days after proof of claim has been furnished to the Claims Administrator, nor more than two years after the date of which the Covered Expense was incurred.

SECTION 10

PRIVACY PRACTICES OF THE CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN

Use and Disclosure of Health Information. The Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure for your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. Health care operations include such activities as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- Business planning and development, including cost management and planning related analyses and formulary development;
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor (Your Employer). The Plan may disclose your health information to the Plan Sponsor for administration functions performed by the Plan Sponsor on behalf of the Plan, such as enrollment and eligibility, and assistance with claim questions. In addition, the Plan may provide summary health information to the Plan Sponsor so the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan also may disclose to the Plan Sponsor information on whether you are participating in the Health Plan.

When Legally Required. The Plan will disclose your health information when it is required to do so by any federal, state or local law:

- **To conduct health oversight activities.** The Plan may disclose your health information to a health oversight agency for authorized activities, including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclosure your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

- **In connection with judicial and administrative proceedings**. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding In response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

- **For law enforcement purposes.** As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan as a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

- **In the event of a serious threat to health or safety.** The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

- **For specified government functions.** In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services of the president and others, and correctional institutions and inmates.

- **For Workers' Compensation.** The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

Authorization to Use or Disclose Health Information. Other than as stated above, the Plan will not disclose your health information unless it has your written authorization. If you authorize the Plan to use or disclose your health information,

you may revoke that authorization in writing at any time.

Your Rights with Respect to your Health Information. You have the following rights regarding your health information that the Plan maintains:

Your Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health Information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Plan's Privacy Official.

Your Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Plan's Privacy Official. The Plan will attempt to honor your reasonable requests for confidential communications.

Your Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Plan's Privacy Officer. The Plan may deny the request if It does not include a reason to support the amendment. The request also may be denied if your records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Your Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Plan's Privacy Official. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Your Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Plan's Privacy Official.

Duties of the Plan. The Plan is required by law to maintain the privacy of your health information as set forth in this Notice, and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. For complaints involving this Plan, write to Region II, Office for Civil Rights, U.S. Dept. of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278. Any complaints to the Plan should be made in writing to the Plan's

Privacy Official. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, please contact the Plan's Privacy/Security Official at CASEBP, P.O. Box 383, Grand Gorge, NY 12434. Phone: 607-588-8917.

CERTIFICATION

The undersigned Chairman of the Board of Directors hereby certifies that the attached Plan is a true and correct copy of the Catskill Area School Employee Benefit Plan and was adopted by a vote of the members of the Board of the 25th day of April 2006 to be effective as of the 1st day of January 2006, and that [s]he was authorized to sign this document on behalf of the Board of Directors.

Chairman of the Board of Directors