This is Your
PREFERRED PROVIDER ORGANIZATION CERTIFICATE OF COVERAGE

Issued by

Catskill Area Schools Employee Benefit Plan (CASEBP)

This Certificate of Coverage ("Certificate") explains the benefits available to You under the CASEBP Municipal Cooperative Health Benefit Plan (hereinafter referred to as "We", "Us", or "Our"). This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

In-Network Benefits. In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our network. You should always consider receiving health care services first through the in-network benefits portion of this Certificate.

Out-of-Network Benefits. The out-of-network benefits portion of this Certificate provides coverage when you receive Covered Services from Non-Participating Providers, Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any differences between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the Superintendent of the Department of Financial Services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability.

The contents of this Certificate, which describes the plan provisions, are subject to approval by the New York State Department of Financial Services. The benefits, terms and conditions could change without prior notice pending its review.

APPROVED
STATE OF NEW YORK

FEB 27 2014

SUPERINTENDENT
BENJAMIN M. LAWSKY

President

Form: CASEBP2013

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 may be contacted at, 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 – Upon approval from the Department of Financial Services.

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 Department of Financial Services.

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SECTION I

DEFINITIONS

Defined terms will appear capitalized throughout the Certificate.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Section IV of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

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

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.

Certificate: This Certificate issued by CASEBP, including the Schedule of Benefits and any attached riders.

Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate.

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.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

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

Cover, Covered or Covered Services: The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment (DME): Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

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

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical

probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Employee - 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.

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an Agreement with Us.

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

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

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

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

Hospital: A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- 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 rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

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

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. In-Network Deductible applies before any Coinsurance or Copayments are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover.

Medically Necessary: See Section II of this Certificate for the definition.

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

Member: The Subscriber and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for Out-of-Network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website www.oncboces.org/casebp.cfm or upon Your request to Us. The list will be revised from time to time by Us. You will pay more to see a Non-Participating Provider.

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

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

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

Primary Care Physician: A Participating Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who typically is an internal medicine, family practice or pediatric doctor and who directly provides or coordinates a range of health care services for You.

Provider: A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), licensed Health Care Professional or Facility licensed, certified or accredited as required by state law.

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

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Preauthorization requirements and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage including Otsego, Chenango, Delaware, Herkimer, and Schoharie Counties.

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

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

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

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 Department of Financial Services.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

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

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

Us, We, Our: CASEBP and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

HOW YOUR COVERAGE WORKS

1. **Your Coverage under this Certificate.** Your employer (referred to as the "Group contract holder") has purchased a Group health insurance Contract from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

2. Covered Services. You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIV of this Certificate; and
- Received while Your Certificate is in force.

3. Participating Providers. To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call 800-962-6294.
- Visit our website www.oncboces.org/casebp.cfm.

4. The Role of Primary Care Physicians. This Certificate does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a Referral from a PCP before receiving Specialist care.

5. Out-of-Network Services. We Cover the services of Non-Participating Providers outside Our Service Area. However, some services are only Covered when you go to a Participating Provider. See the Schedule of Benefits in Section XIV of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

5. Services Subject To Preauthorization. Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits in Section XIV of this Certificate.

6. Preauthorization/Notification Procedure. If You seek coverage for services that require Preauthorization or notification, You must call the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Within the first three months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.

You must contact Us to provide notification as follows:

- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines

7. Failure to Seek Preauthorization or Provide Notification. If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

8. Medical Management. The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

9. Care Must Be Medically Necessary. We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; 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 Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See Sections VIII and I of this Certificate for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

10. Important Telephone Numbers and Addresses.

CLAIMS *Submit claim forms to this address.
CASEBP
PO BOX 383
Grand Gorge, NY 12434

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
CASEBP
PO BOX 383
Grand Gorge, NY 12434

MEMBER SERVICES
Phone 607-588-8917 or 800-962-6294

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

OUR WEBSITE
www.oncboces.org/casebp.cfm

SECTION III

ACCESS TO TRANSITIONAL CARE

When Your Provider Leaves the Network
If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

New Members In a Course of Treatment
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV
COST-SHARING EXPENSES AND ALLOWED AMOUNT

1. Deductible. Except where stated otherwise, You must pay the amount in the Schedule of Benefits in Section XIV of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than Individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible. However, after Deductible payments for all persons covered under this Certificate total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply towards Your In-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible**

2. Copayments. Except where stated otherwise, after You have satisfied the annual Deductible as described above You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XIV of this Certificate for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

3. Coinsurance. Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits in XIV of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

4. In Network Out-of-Pocket Limit. When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in XIV of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered In-Network Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family In-Network Out-of-Pocket Limit in payment of In-Network Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. Cost-Sharing for out-of-network services does not apply towards Your In-Network Out-of-Pocket Limit.

5. Out-of-Network Out-of-Pocket Limit. This certificate has a separate out-of-network out-of-pocket limit in the Schedule of Benefits in Section XIV. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-OF-Network Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in XIV of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket

Limit in payment of Out-of-Network Deductibles, Copayments and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards Your Out-of-Pocket Limit.**

6. Your Additional Payments for Out-of-Network Benefits. When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Coinsurance and Deductible described in the Schedule of Benefits in Section XIV of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

7. Allowed Amount. "Allowed Amount" means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

For Facilities in Our Service Area, the Allowed Amount will be based on Our Participating Provider fee schedule or rate.

For all other Providers in Our Service Area, the Allowed Amount will be the 85th Percentile of the Fair Health rate

For Facilities outside Our Service Area, the Allowed Amount will be based on Our Participating Provider fee schedule or rate.

For all other Providers outside Our Service Area, the Allowed Amount will be the amount based on Our Participating Provider fee schedule or rate.

If there is no amount as described above, the Allowed Amount will be the 85th Percentile of the Fair Health rate

We reserve the right to negotiate a lower rate with Non-Participating Providers.

See section VI of the Certificate for the Allowed Amount for an Emergency Condition.

SECTION V
WHO IS COVERED

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 child must be "available" for adoption and the legal process of adoption must have begun.

(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 for students not pursuing a high school diploma 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 an 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, who is not an eligible foster child as defined above, 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 Adults Covered through Age 29. If You selected Family coverage, Your young adult Child will be eligible for coverage through the age of 29 years when the young adult:

A. Is unmarried;

B. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;

C. Lives, works or resides in New York State or Our Service Area.

The young adult need not live with or be financially dependent upon You or be a student in order to be covered.

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 may be entitled to continue coverage for three months beyond the last day of the 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/she continues to pay the premiums. Your Dependent Survivor(s) may be required to pay the full cost of coverage. Check with your District Benefits Clerk for contribution rates and coverage options. 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, (General Municipal Law 92-a).

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 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, or (2) they wish to enroll a previously eligible but un-enrolled spouse or child who meets the definition of Dependent.

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 last 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; 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)

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 VI
COVERED SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 800 962-6294 or visit Our website at www.oncboces.org/casebp.cfm for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care

We Cover well-baby and well-child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance.

B. Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.
Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website www.oncboces.org/casebp.cfm or will be mailed to You upon request.

You are eligible for a physical examination once every plan year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations

We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive services is available on Our website www.oncboces.org/casebp.cfm , or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

E. Mammograms

We Cover mammograms for the screening of breast cancer as follows:

- one baseline screening mammogram for women age 35 through 39;
- one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

F. Family Planning & Reproductive Health Services

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug benefit in Section VI of the Certificate, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.
We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA") and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

H. Screening for Prostate Cancer
We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Pre-Hospital Emergency Medical Services and Ambulance Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. We also Cover emergency ambulance transportation by a licensed ambulance service either ground, water or air ambulance to the nearest Hospital where Emergency Services can be performed.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an

Emergency Condition do not require Preauthorization.

Non-Emergency Ambulance Transportation:

We Cover non-emergency ambulance transportation by a licensed ambulance service either ground or air ambulance, as appropriate between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.
- From an acute Facility to a sub-acute setting.

See the schedule of benefits in Section XIV of this Certificate for any Preauthorization requirements for non-emergency transportation.

Limitations/Terms of Coverage:

Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Emergency Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

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

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

- Serious impairment to such person's bodily functions;

- Serious dysfunction of any bodily organ or part of such person; or

- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and

- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

A. Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department.**

Follow-up care or routine care provided in a Hospital emergency department is not Covered.

B. Emergency Hospital Admissions

In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed in this Certificate and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

C. Payments Relating to Emergency Services Rendered

The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service received and if more than one amount is negotiated, the median of the amounts; (2) 100% of the Allowed Amount for Services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance or Copayment.

Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in or out of Our Service Area.**

A. In-Network
You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network
You may obtain Urgent Care from a Non-Participating Urgent Care Center or Physician.

If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.

Outpatient and Professional Services

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Advanced Imaging Services: We Cover PET scans, MRI, nuclear medicine, and CAT scans.

Allergy Testing and Treatment: We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

Ambulatory Surgery Center: We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

Chemotherapy: We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug section of this Certificate.

Chiropractic Services: We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

Dialysis: We Cover dialysis treatments of an acute or chronic kidney ailment.

Habilitation Services: We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition combined therapies per year.

Home Health Care: We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation and Habilitation Services".

Interruption of Pregnancy: We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We Cover elective abortions.

Infertility Treatment: We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.

- Comprehensive Infertility Services . If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

- Exclusions and Limitations
    a. In vitro, GIFT and ZIFT procedures.
    b. Cost for an ovum donor or donor sperm.
    c. Sperm storage costs.
    d. Cryopreservation and storage of embryos.
    e. Ovulation predictor kits.
    f. Reversal of tubal ligations. Reversal of vasectomies.
    g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
    h. Sex change procedures.
    i. Cloning.
    j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
    k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count towards Your home health care visit limit.

Laboratory Procedures, Diagnostic Testing and Radiology Services: We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

Maternity and Newborn Care: We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See Section VI of the Certificate for coverage of inpatient maternity care.

We Cover the cost of renting or the purchase of one breast pump per pregnancy for the duration of breast feeding.

Medications for Use in the Office: We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

Office Visits. We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls

Outpatient Hospital Services: We Cover Hospital services and supplies as described in the Inpatient Hospital section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

Preadmission Testing: We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

Rehabilitation Services: We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition combined therapies per year. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered speech, physical and occupational therapy services must begin within six months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

If these criteria are not met, payment for 20 visits may be considered subject to an office visit copay or deductible and coinsurance.

In no event will the therapy continue beyond 365 days after such event.

Second Opinions:

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an In-Network basis.

- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.

- Required Second Surgical Opinion. We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    a. The second opinion must be given by a board certified Specialist who personally examines You.
    b. If the first and second opinions do not agree You may obtain a third opinion.
    c. The second and third surgical opinion consultants may not perform the surgery on You.

- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion.

After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

Surgical Services: We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

Oral Surgery: We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Reconstructive Breast Surgery: We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

Other Reconstructive and Corrective Surgery: We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or

- It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- It is otherwise Medically Necessary.

Transplants: We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits

Autism Spectrum Disorder: We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- Assistive Communication Devices. We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered however, We will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a

licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

- Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized services plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit.

Any Deductible, Copayment, or Coinsurance that applies to office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

Diabetic Equipment, Supplies and Self-Management Education: We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

Supplies

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones

- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Self-Management Education
Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
- Upon the referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

Limitations
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

Durable Medical Equipment and Braces: We Cover the rental or purchase of durable medical equipment and braces.

Durable Medical Equipment
Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment.

Braces
We Cover braces that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost

of repairs or replacement that are the result of misuse or abuse by You).

Hospice: Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

Medical Supplies: We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. Please see the "Diabetic Supplies, Education and Self-Management" section of this Certificate for a description of diabetic supply Coverage.

Prosthetics:

External Prosthetic Devices: We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only covered under the vision benefit in Section VI of this Certificate. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown. Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement. We also Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Internal Prosthetic Devices: We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Inpatient Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Hospital Services: We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

Observation Services: We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services: We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

Inpatient Stay for Maternity Care. We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education,

assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

Inpatient Stay for Mastectomy Care: We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

Autologous Blood Banking Services: We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

Rehabilitation Services: We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

1. such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. it is ordered by a Physician; and
3. You have been Hospitalized or have undergone surgery for such illness or injury.

Covered Services must begin within six months of the later to occur:

1. the date of the injury or illness that caused the need for the therapy;
2. the date You are discharged from a Hospital where surgical treatment was rendered; or
3. the date outpatient surgical care is rendered.

Skilled Nursing Facility: We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate). We Cover up to 45 days, per Plan Year, for non-custodial care.

End of Life Care: If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.

3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

Limitations/Terms of Coverage:

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.

2. We do not Cover radio, telephone and television expenses, or beauty or barber services.

3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Mental Health Care Services

Inpatient Services: We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Certificate. However, Coverage for inpatient services for mental health care is limited to Facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

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.

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 IX of this document.

Outpatient Services: We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage:

1. We will not Cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

2. We will not Cover mental health benefits or services for 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.

3. We will not Cover services solely because they are ordered by a court.

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, electro-convulsive 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.

Substance Use Services

Inpatient Services: We Cover 28 Days per Confinement, 42 days lifetime per Covered Person for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services: We Cover 60 Visits per Plan Year outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

Coverage includes up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Prescription Drug Coverage

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Covered Outpatient Prescription Drugs

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

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

Covered Prescription Drugs include, but are not limited to:

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

Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at www.oncboces.org/casebp.cfm. You may also inquire if a specific drug is Covered under this Certificate by contacting us at the number on Your ID card.

Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in Section XIV of this Certificate.

Benefit and Payment Information

1. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the Schedule of Benefits in Section XIV of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

   You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 and highest for Prescription Drugs on Tier 3. Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

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

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

   - The applicable Cost-Sharing; or

- The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

3. **Non-Participating Pharmacies:** If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.

4. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

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

   If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, Your coverage will be subject to the Out-of-Network Benefit for that Prescription Drug.

   Following are the therapeutic classes of Prescription Drugs that are included in this program:
   - Age related macular edema
   - Anemia, neutropenia, thrombocytopenia
   - Contraceptives
   - Crohn's Disease
   - Cystic Fibrosis
   - Cytomegalovirus
   - Endocrine disorders/Neurologic disorders such as infantile spasms
   - Enzyme Deficiencies/Liposomal Storage Disorders
   - Gaucher's Disease
   - Growth Hormone
   - Hemophilia
   - Hepatitis B, Hepatitis C
   - Hereditary Angioedema
   - HIV/AIDS
   - Immune Deficiency
   - Immune Modulator
   - Infertility
   - Iron Overload

- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis,Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

5. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier and You are responsible for paying the lower of:
    - The applicable Cost-Sharing; or
    - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

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

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

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website www.oncboces.org/casebp.cfm or by calling the Customer Service number on Your ID card.

6. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per Plan Year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status at Our website www.oncboces.org/casebp.cfm] or by calling the Customer Service number on Your ID card.

7. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name

Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in Section IX of the Certificate.

8. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply.

   Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

   Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to Section IX of the Certificate.

9. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIV of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Certificate.

Medical Management

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, We will contact Your Provider to determine if Preauthorization should be given. Should You choose to purchase the Prescription Drug without obtaining

Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please visit our website or call the Customer Service number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification. Including a Prescription Drug or related item on the list does not promise coverage under Your Plan. Your Provider may check with Us to find out which Prescription Drugs are Covered

2. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website or call the Customer Service at the phone number on Your ID Card.

Limitations/Terms of Coverage

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

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding.

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

5. Injectable drugs (other than self-administered injectable drugs) are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for

diabetic insulin, oral hypoglycemics, and diabetic supplies will be provided under this section of the Certificate if the Cost-Sharing is more favorable to you under this section of the Certificate than the Cost-Sharing under Section IV of the Certificate.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Certificate.

8. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

9. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

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

11. Your benefit for insulin and diabetic Prescription Drugs, supplies and equipment will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Cost-Sharing under section IV of the Certificate

12. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in Section IX of this Certificate.

13. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

14. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

General Conditions

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours.

Definitions

Terms used is this section are defined as follows. (Other defined terms can be found in the definitions section of this Certificate).

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

Designated Pharmacy: A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website or by calling the Customer Service number on Your ID card.

Generic Drug: A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a "generic" by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

Non-Participating Pharmacy: A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members.

Participating Pharmacy: A pharmacy that has:
- entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- has been designated by Us as a Participating Pharmacy.

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

Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill . A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Drug Cost: The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Plan includes Coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

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

Vision Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Vision Care: We Cover emergency, preventive and routine vision care.

Vision Examinations: We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period for children under age 19, and one vision examination in any twenty-four (24) month period for adults age 19 and over, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Opthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

Prescribed Lenses & Frames: We Cover standard prescription lenses or contact lenses once in any twelve (12) month period for children under age 19, and one vision examination in any twenty-four (24) month period for adults age 19 and over, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any twelve (12) month period for children under age 19, and standard frames adequate to hold lenses once in any twenty-four (24) month period for adults age 19 and over, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

SECTION VII

Exclusions

No Coverage is available under this Certificate for the following:

Aviation. We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care. We do not Cover services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

Cosmetic Services. We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in Section IX of this Certificate.

Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services to treat Your Emergency Condition.

Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the oral surgery section of this Certificate.

Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See Section IX of this Certificate for a further explanation of Your Appeal rights.

Felony Participation. We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

Foot Care. We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this Certificate. For foot care related to diabetes, see Section VI of this Certificate.

Government Facility. We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Medically Necessary. In general, We will not Cover any health care service, procedure, treatment, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program. We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service. We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance. We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. 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.

Services Separately Billed by Hospital Employees. We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services Provided by a Family Member. We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

Services With No Charge. We do not Cover services for which no charge is normally made.

Services not Listed. We do not Cover services that are not listed in this Certificate as being Covered.

Vision Services. We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Certificate.

Workers' Compensation. We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

War. We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

SECTION VIII

CLAIM DETERMINATIONS

Claims. A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

Notice of Claim. Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website. Completed claim forms should be sent to the address in Section VIII of this Certificate.

Timeframe for Filing Claims. Claims for services must be submitted to Us for payment within 18 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 18 month period, You must submit it as soon as reasonably possible.

Claims for Prohibited Referrals. We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by N.Y. Public Health Law § 238-a(1).

Claim Determinations. Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to Section IX of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see Sections II and IX of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

Pre-service Claim Determinations.
If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

Post-service Claim Determinations.
If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION IX
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEAL

Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance. You can contact Us by phone, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 45 calendar days of receipt of all necessary information.

Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The

acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: that are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov]

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

Utilization Review

Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 800-541-7403.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us.

Preauthorization Reviews

If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of receipt of the request.

If We need additional information, We will request it within 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) within 72 hours of receipt of the necessary

information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

Concurrent Reviews
Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You or Your designee, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

Retrospective Reviews
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective Review of Preauthorized Services
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration
If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

Utilization Review Internal Appeals
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

First Level Appeal
If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Expedited Appeals. Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Second level Appeal

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made.

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

External Appeal

I. YOUR RIGHT TO AN EXTERNAL APPEAL

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I above.

III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external appeal in I above and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

IV. THE EXTERNAL APPEAL PROCESS

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

V. YOUR RESPONSIBILITIES

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION X
Coordination of Benefits

This section applies when you also have group health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

Definitions

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is other group health coverage with which We will coordinate benefits. The term "plan" includes:

1. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

2. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: (1) the plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;

    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XI

Termination of Coverage

Group:

Coverage under this Certificate will automatically be terminated on the first of the following to apply. In all cases of termination, unless otherwise noted below, We will provide at least 30 days prior written notice to the Group.

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Coverage will terminate upon the Subscriber's death, unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate for your Dependents as of the last day of the third full month for which the Premium has been paid (the school district will make the Employee/Retiree's contribution).

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the Child turns 26 years of age. For all other Dependents, the date in which the Dependent ceases to be eligible.

6. The end of the month during which the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

7. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber.

8. The date that the The Certificate is terminated. If We terminate and/or decide to stop offering a particular class of the Certificates, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.

9. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market, in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

No termination of coverage shall prejudice the right to a claim for benefits which arose prior to such termination.

See Section XII of this Certificate for Your right to continuation of this coverage and Section III of this Certificate for Your right to conversion to an individual Contract.

SECTION XII
WHAT HAPPENS IF YOU LOSE COVERAGE

EXTENSION OF BENEFITS

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Certificate terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

When You May Continue Benefits

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

Termination of Extension of Benefits

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment);
- With respect to the 12 month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

Limits on Extended Benefits

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends;
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your Covered Children.

2. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Divorce or legal separation of the Covered employee;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

3. If You are a Covered Child, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Loss of Covered Child status under the plan rules;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from Your employer in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group contract holder.

The contract holder can charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after Your coverage would have terminated because of termination of employment;
2. If You are a Covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date The Certificate terminates. However, if the The Certificate is replaced with similar coverage, You have the right to become covered under the new The Certificate for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See Section XII of the Certificate.

Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

2. You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the The Certificate holder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption

extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.

2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

Age 29 Dependent Coverage Extensions Young Adult Option

Your Child may be eligible to purchase his or her own individual coverage under Your Group's contract through the age of 29 if he or she 1) is under the age of 30; 2) is not married; 3) is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; 4) lives, works or resides in New York State or Our Service Area; and 5) is not covered by Medicare. The Child may purchase coverage even if he or she is not financially Dependent on his or her parent(s) and does not need to live with his or her parent(s).

Your Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the The Certificate holder or The Certificate holder's designee receives notice and We receive Premium payment;
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the The Certificate holder or The Certificate holder's designee receives notice of election and We receive Premium payment.

You or Your Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. Your Child's children are not eligible for coverage under this option.

SECTION XIII
GENERAL PROVISIONS

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.** You cannot assign any benefits under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate.

3. **Changes in This Certificate.** We may unilaterally change this Certificate upon renewal, if We give the The Certificate holder 30 days' prior written notice.

4. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.

5. **Clerical Error.** Clerical error, whether by the The Certificate holder; You or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

7. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

8. **Furnishing Information and Audit.** The The Certificate holder and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of

Your care. The The Certificate holder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the The Certificate holder's office.

9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

10. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

11. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

12. **Material Accessibility.** We will give The Certificate holder, and the The Certificate holder will give You, identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
    - A written description of Our quality assurance program.
    - A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.

- Provider affiliations with Hospitals.

- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records or to the address of the The Certificate holder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: CASEBP, P.O. Box 383, Grand Gorge, NY 12434.

15. **Premium Refund**. We will give any refund of Premiums, if due, to the The Certificateholder.

16. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

17. **Renewal Date.** The renewal date for the Certificate is the anniversary of the effective date of the The Certificate each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the The Certificate holder as permitted by the Certificate, or by You upon 30 days' prior written notice to the The Certificate holder.

18. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

19. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise

required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

20. **Severability.** The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.

21. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

    Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

    We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

22. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.

23. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact us at 800-962-6294 to access these services.

24. **Venue for Legal Action.** If a dispute arises under this Certificate, it must be resolved

in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.

25. **Waiver.** The waiver by any party of any breach of any provision of the Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

26. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by the President of the Board of Trustees. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing.

27. **Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

28. **Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

29. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us

in reviewing a treatment or claim; and

- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.