This is Your

TRADITIONAL PLAN (POINT OF SERVICE)
SUMMARY PLAN DESCRIPTION OF COVERAGE

Issued by

JEFFERSON-LEWIS ET. AL. SCHOOL EMPLOYEE'S HEALTHCARE PLAN

This Summary Plan Description of Coverage ("Summary Plan Description") explains the benefits available to You under an agreement between Jefferson-Lewis et. al. School (hereinafter referred to as "We", "Us" or "Our") and Your employer. This Summary Plan Description is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Summary Plan Description or added thereafter.

This Summary Plan Description offers You the option to receive Covered Services on two benefit levels:

1. **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 the Aetna Choice Point of Service II network and Participating Pharmacies in Our Express Scripts network who are located within Our Service Area. You should always consider receiving health care services first through the in-network benefits portion of this Summary Plan Description.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Summary Plan Description 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 difference between the Allowed Amount and the Non-Participating Provider's charge. Some Covered Services, such as prescription drugs, are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Summary Plan Description for more information.

READ THIS ENTIRE SUMMARY PLAN DESCRIPTION CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THE SUMMARY PLAN DESCRIPTION.

This Summary Plan Description is governed by the laws of New York State.

Signature:

By________________________________

Title ________________________________

Date ________________________________

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SECTION I: Definitions

Defined terms will appear capitalized throughout this Summary Plan Description.

Acute: The onset of disease or injury, or a 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 the Cost-Sharing Expenses and Allowed Amount section of this Summary Plan Description 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.

Child, 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 Summary Plan Description.

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. The amount can vary by the type of Covered Service.

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 Copayments, Deductibles and/or Coinsurance.

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

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

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): 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
- 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 that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Public Health Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder 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 as a contract holder.

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

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law 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 Summary Plan Description.

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 New York Public Health Law Article 40 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 42 U.S.C. Section 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 rehabilitation 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. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the 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. The In-Network Deductible applies before any Copayments or Coinsurance 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 (e.g., a Prescription Drug Deductible) 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 or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of this Summary Plan Description for the definition.

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

Member: The Subscriber or a covered Dependent 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.

Network: The Providers We have contracted with to provide health care services to You.

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. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the 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 Copayments or Coinsurance 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 (e.g., a Prescription Drug Deductible) 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 health care services to You. A list of Participating Providers and their locations is available on Our website at www.meritain.com or upon Your request to Us. The list will be revised from time to time by Us.

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 Summary Plan Description or any anniversary date thereafter, during which the Summary Plan Description 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, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Summary Plan Description.

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 ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. 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 ("PCP"): A Participating Physician who typically is an internal medicine, family/general practice, obstetrics and gynecology or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, Durable Medical Equipment, medical supplies, or any other equipment or supplies that are Covered under this Summary Plan Description that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

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 Summary Plan Description that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, 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. Our Service Area consists of: Jefferson and Lewis 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, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; 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 Summary Plan Description is issued.

Summary Plan Description: This Summary Plan Description issued by Jefferson- Lewis et. al., including the Schedule of Benefits and any attached riders.

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 (other than a Hospital) that provides Urgent Care.

Us, We, Our: Jefferson-Lewis, et. al. Schools and anyone to whom We legally delegate performance, on Our behalf, under this Summary Plan Description.

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

You, Your: The Member.

SECTION II: How Your Coverage Works

A. Your Coverage Under this Summary Plan Description.

We will provide the benefits described in this Summary Plan Description to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Summary Plan Description is not a contract between You and Us. You should keep this Summary Plan Description with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Summary Plan Description only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Summary Plan Description; and
- Received while Your Summary Plan Description is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request.
- Call the number on Your ID card.
- Visit Our website at www.meritain.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);

- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Physicians.
This Summary Plan Description 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.**

E. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Jefferson- Lewis et.al School Employees' Healthcare Plan and Aetna Choice Point of Service (POS) II Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our Network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Out-of-Network Services.
We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Summary Plan Description 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.

G. Services Subject to Preauthorization.
Our Preauthorization is not required before You receive certain Covered Services.

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

I. Medical Necessity.

We Cover benefits described in this Summary Plan Description 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.

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 at least as likely to produce equivalent therapeutic or diagnostic results.

See the Utilization Review and External Appeal sections of this Summary Plan Description for Your right to an internal Appeal and external Appeal of Our determination that a service is not Medically Necessary.

J. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
   - For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
     - A participating Physician is unavailable at the time the health care services are

performed;
  - A non-participating Physician performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not Covered by Us. For a surprise bill, a Referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Summary Plan Description.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.jefflewishealth.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Our website and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

K. Delivery of Covered Services Using Telehealth.
If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to Utilization Review and quality assurance requirements and other terms and conditions of the Summary Plan Description that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

L. Early Intervention Program Services.
We will not exclude Covered Services solely because they are Early Intervention Program services for infants and toddlers under three years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Summary Plan Description, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Summary Plan Description.

M. Case Management.
Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management programs that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Summary Plan Description. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

N. Disease Management Program
The Disease Management Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with Members to help them improve their chronic diseases and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and depression. We use medical and pharmacy claims to identify Members who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates may be initially identified using a Health Condition Survey.
The survey is a general screening questionnaire available to all Members age 18 and over

that asks a few questions about each of the conditions managed in the program. Program participants can also be identified through Referrals from the Preauthorization process, Member self-referrals, other Medical Management programs, the employer, or the Member's Physician.

O. Important Telephone Numbers and Addresses.

CLAIMS
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
*Submit claim forms to this address.

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS Call 1-800-925-2272 or to submit an appeal or grievance by mail:
Meritain Health
Jefferson Lewis Grievance & Appeal
PO Box 27469
Golden Valley, MN 55427

MEMBER SERVICES
1-800-925-2272 or call the number on Your ID card
*Member Services Representatives are available Monday – Friday 8:00 a.m. – 9:00 p.m.

PREAUTHORIZATION 1-800-242-1199

OUR WEBSITE
www.meritain.com

PLAN MANAGER
853 James Street
PO BOX #456
CLAYTON, NY 13624

SECTION III: Access to Care and Transitional Care

A. Authorization to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider.
Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be Covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. 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 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 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, authorizations, 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.

C. 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 Summary Plan Description becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Summary Plan Description. 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 Summary Plan Description 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 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

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Summary Plan Description 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 Summary Plan Description. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Summary Plan Description collectively total the family Deductible amount in the Schedule of Benefits section of this Summary Plan Description in a Plan Year, no further Deductible will be required for any person covered under this Summary Plan Description for that Plan Year.

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

The Deductible runs from January 1 to December 31 of each calendar year.

Carryover Deductible.

Amounts that accumulate towards Your Deductible for Covered Services during the last three (3) months in a Plan Year and applied to the Deductible for that Plan Year will also be counted toward Your Deductible for the next Plan Year.

B. Copayments.

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

C. Coinsurance.

Except where stated otherwise, after You have satisfied the 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 section of this Summary Plan Description. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of In-Network and Out-of- Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Summary Plan Description, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Scheduled of Benefits section of this Summary Plan Description, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Summary Plan Description have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Summary Plan Description, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

The Preauthorization; notification penalty described in the How Your Coverage Works section of this Summary Plan Description does not apply toward Your In-Network Out- of-Pocket Limit. The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Network Out-of-Pocket Limit.
This Summary Plan Description does not have a separate Out-of-Network Out-of- Pocket Limit in the Schedule of Benefits section of this Summary Plan Description for out-of-network benefits. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Pocket Limit.

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out- of-Pocket Limit. The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

F. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Summary Plan Description, 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 Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co- surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

G. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Summary Plan Description, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

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

1. **Participating Facilities in Our Service Area**.
   For a participating Facility in Our Service Area, the Allowed Amount will be the amount We have negotiated with the Facility.

2. **For All Other Participating Providers in Our Service Area**.
   For all other Participating Providers in Our Service Area, the Allowed Amount will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

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

1. **Facilities.**
   For Facilities, the Allowed Amount will be, the lesser of, the amount We (or a contractor acting on Our behalf) have negotiated with the Facility or the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.

   Our Allowed Amount for non-participating Facilities equates to approximately 90% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.

2. **For All Other Providers.**
   For all other Providers, the Allowed Amount will be, the lesser of, the amount We (or a contractor acting on Our behalf) have negotiated with the Provider or the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.

   Our Allowed Amount for non-participating Providers equates to approximately 90% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.

The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non- Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website at www.meritain.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

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

See the Emergency Services and Urgent Care section of this Summary Plan Description for the Allowed Amount for Emergency Services rendered by Non- Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Summary Plan Description for the Allowed Amount for Pre- Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V: Who is Covered

A. Who is Covered Under this Summary Plan Description.
You, the Subscriber to whom this Summary Plan Description is issued, are covered under this Summary Plan Description. You must live, work, or reside in Our Service Area to be covered under this Summary Plan Description. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Summary Plan Description.
If You selected family coverage, Children covered under this Summary Plan Description include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order or Foster Children. Grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Summary Plan Description at any time.

D. When Coverage Begins.
Coverage under this Summary Plan Description will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual coverage, You must also notify Us of Your desire to switch to family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.
You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption, or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

If You die, Your survivor Dependents could be eligible to continue plan enrollment under his or her own individual coverage. Each participating school has different rules concerning survivor Dependent eligibility. Your participating school's healthcare clerk can provide details concerning their rules for survivor Dependent eligibility. If Your survivor Dependent is not eligible for this enrollment, she or he may be eligible for COBRA. See the "Continuation of Coverage".

SECTION VI: Preventive Care

Please refer to the Schedule of Benefits section of this Summary Plan Description for Cost-Sharing requirements, day or visit limits, and any Preauthorization 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 or 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 the number on Your ID card or visit Our website 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 consists 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
(1) 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 recommended 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, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our *w*ebsite at www.jefflewishealth.com, or will be mailed to You upon request.

You are eligible for a physical examination once every calendar 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.

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.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. 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 at www.jefflewishealth.com, 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, which may be less frequent than described above.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member’s Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

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

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance.

F. Family Planning and 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 Coverage section of this Summary Plan Description, patient education and counseling on use of contraceptives and related topics follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance.

We also Cover vasectomies subject to 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 the Prescription Drug Coverage section of this Summary Plan Description. Bone mineral density measurements or tests, drugs or devices shall include those Covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- 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 osteoporosis screening 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.

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.

SECTION VII: Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Summary Plan Description for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued certificate under the New York 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 must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 90th percentile or the Provider’s billed charges.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat the Your Emergency Condition.

B. 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; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover 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.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- 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 (1) of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

D. Payments for Air Ambulance Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

- We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

- If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

- You are responsible for any In-Network Cost-Sharing for air ambulance services. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us.

SECTION VIII: Emergency Services and Urgent Care

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

A. Emergency Services.

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

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
- 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 in a Hospital.

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

1. **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 are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Summary Plan Description and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (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.

   If a dispute involving a payment for physician or Hospital services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician or Hospital services.

   You are responsible for any In-Network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. Additionally, if You assign benefits to a Non-Participating Provider in writing, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Copayment, Deductible or Coinsurance, You should contact Us.

B. 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 typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in or out of Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We Cover 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.

SECTION IX: Outpatient and Professional Services

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

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

B. 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.

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

D. Biomarker Testing
Biomarker precision medical testing will be payable under the plan purposes of diagnosis, treatment, or appropriate management of, or ongoing monitoring to guide treatment decisions for, a member's disease or condition when one or more of the following recognizes the efficacy and appropriateness of the testing:

- labeled indications for a test approved or cleared by the federal food and drug administration or indicated tests for a food and drug administration approved drug;
- CMS national coverage determinations or Medicare administrative contractor local coverage determinations; or
- nationally recognized clinical practice guidelines; or
- peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

E. Chemotherapy and Immunotherapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Summary Plan Description.

F. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") 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 laboratory tests will be Covered in accordance with the terms and conditions of this Summary Plan Description.

G. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:
- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Summary Plan Description.

We do not Cover: the costs of the investigational drugs or devices; the costs of non- health services required for You to receive the treatment; the costs of managing the research; or costs that would not be Covered under this Summary Plan Description for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:
- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis.
We Cover dialysis treatments of an Acute or chronic kidney ailment.

I. Gender Reassignment Services:

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including Medical Necessity requirements, Medical Management, Prescription Drug programs, and exclusions for Cosmetic services (except as allowed per guidelines). Additional guidelines or requirements may need to be satisfied before benefits are paid under the Plan. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as gender reassignment (sex change) Surgery, breast removal, gonadectomy, breast implants, hormone therapy, and psychotherapy.

Services that are excluded on the basis that they are Cosmetic include, but are not limited to: abdominoplasty; blepharoplasty; body contouring (liposuction of waist); brow lift; calf implants; cheek/malar implants; chin/nose implants; collagen injections; construction of a clitoral hood; drugs for hair loss or growth; face lifting; facial bone reduction; facial feminization and masculinization Surgery; feminization of torso; forehead lift; jaw reduction (jaw contouring); hair removal (e.g., electrolysis, laser hair removal; exception: a limited number of electrolysis or laser hair removal sessions are considered Medically Necessary for skin graft preparation for genital Surgery); hair transplantation; lip enhancement; lip reduction; liposuction; masculinization of torso; mastopexy; neck tightening; nipple reconstruction; nose implants; pectoral implants; pitch-raising Surgery; removal of redundant skin; rhinoplasty; skin resurfacing (dermabrasion/chemical peel); tracheal shave (reduction thyroid chondroplasty); voice modification Surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords); and voice therapy/voice lessons.

J. 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. Limit 80 visits per Plan Year for cardiac rehabilitation, pulmonary rehabilitation, speech therapy and occupational therapy combined (and is combined with Rehabilitation Services). Physical therapy does not apply to the yearly maximum.

K. 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:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription 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 80 visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

L. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such coverage is available as follows:

1. **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.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - 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.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Advanced Infertility Services.** We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of invitro fertilization; and
   - Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** We do not Cover:
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational.

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. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

M. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected 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.

N. Interruption of Pregnancy.
We Cover Medically Necessary abortions including abortions in cases of rape, incest or fetal malformation.

O. 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.

P. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Summary Plan Description for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider.

Q. Nutritional Counseling.
Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically Necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

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

S. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Summary Plan Description 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.

T. 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 (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

U. Prescription Drugs for Use in the Office and Outpatient Facilities.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes.
This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Summary Plan Description.

V. 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. Limit 80 visits per Plan Year for cardiac rehabilitation, pulmonary rehabilitation, speech therapy and occupational therapy combined (combined with Habilitation Services). Physical therapy does not apply to the yearly maximum.

W. Second Opinions.

1. **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.

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

3. **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 approve Covered Services supported by a majority of the Providers reviewing Your case.

X. 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.

The following is a list of specified surgical procedures for services rendered by a surgeon, assistant surgeon or anesthesiologist in an outpatient Hospital, Ambulatory Surgical Center, Urgent Care Center, clinic or Provider's office. This benefit applies only to the following listed surgical procedures that are not considered integral to or part of another surgery, refer to the Schedule of Benefits for Cost-Sharing requirements and any Preauthorization that apply.

Adenoidectomy	Dilatation and curettage (non-obstetrical)	Tubal ligation
Breast biopsy	Laparoscopic sterilization (tubal ligation)	Varicose veins
Cervical biopsy	Laparoscopy	Vasectomy
Cryosurgery	Sigmoidoscopy	
Deviated septum	Tonsillectomy, with or without adenoids	

Y. 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.
- 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.

Z. 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. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

AA. 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;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or

disease of the involved part; or
- Otherwise Medically Necessary.

BB. Telemedicine Program.

1. In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition

Teladoc: Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, call Teladoc at 1-800-TELADOC (1-800-835-2362) or visit www.teladoc.com.

Teladoc benefits include:
- 24/7/365 access to a Physician online or by phone
- Fast treatment
- Talk to a Teladoc Physician from anywhere: at home, work, or while traveling
- Save money by avoiding expensive urgent care or emergency room visits

Call Teladoc:
- When you need care now
- If you’re considering the emergency room or urgent care center for non-emergency issues
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Teladoc providers treat conditions such as:
- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections
- Behavioral health services by board certified psychiatrists, licensed psychologists, therapists, or counselors for persons 18 and over (i.e. anxiety, depression, PTSD/stress, panic disorder, family & marriage issues, eating disorders, grief,

substance use, trauma, ADHD, and work pressures)
- Skin conditions like eczema, acne, rashes, psoriasis, skin infection, rosacea, dermatitis and more (online review of images, uploaded by the Covered Person, to assist with diagnosis and treatment of skin problems)

CC. Transplants (other than those received through the Aetna IOE Program).
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, pancreas and lung transplants; and bone marrow transplants.

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. We do not Cover the medical expenses of a non-Member acting as a donor for You 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; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

All transplants should be performed by Hospitals and Providers that We have specifically approved and designated as Institutes of Excellence to perform these procedures. Refer to Inpatient Services section for details on Institutes of Excellence.

SECTION X: Additional Benefits, Equipment and Devices

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

A. 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 New York Education Law as described below:

1. Equipment and 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
- 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
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aids
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- 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.

2. **Self-Management Education.**
   Diabetes self-management education is 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 New York 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 New York 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.

3. **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 glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

B. Durable Medical Equipment and Braces.
We Cover the rental or purchase of Durable Medical Equipment and braces.

1. **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
   - Appropriate for use in the home.

   Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.
   We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter Durable Medical Equipment.

   We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of Durable Medical Equipment.

2. **Braces.**
   We Cover braces, including orthotic 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 repair or replacement that is the result of misuse or abuse by You.

C. Hearing Aids.

1. External Hearing Aids.

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

2. Cochlear Implants.

We Cover cochlear implants and bone-anchored hearing aids when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids and/or cochlear implants are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

D. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) 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 per Plan Year of Hospice Care. We also Cover five (5) 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 New York 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. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

E. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Summary Plan Description. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Summary Plan Description. 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. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply coverage.

F. Prosthetics.

1. 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.

We do not Cover dentures or other devices used in connection with the teeth 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 Summary Plan Description.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit. Coverage is for standard equipment only.

We Cover the cost of the prosthetic device. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. 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.

Coverage is for standard equipment only.

SECTION XI: Inpatient Services

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

A. 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 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 section of this Summary Plan Description 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 for the same or related causes.

B. 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. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Summary Plan Description.

D. 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 at 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 Summary Plan Description and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Summary Plan Description that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. 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 of time determined to be medically appropriate by You and Your attending Physician.

F. 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.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Limit 100 days per Plan Year for inpatient rehabilitation services.

I. 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 Summary Plan Description). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. Limit 100 days per Plan Year for inpatient Skilled Nursing Facility services.

J. Institutes of Excellence (IOE).

Centers of Excellence are Hospitals (and their Providers) that We have approved and designated for transplant services. We Cover Medically Necessary transplant services (and auxiliary/professional) charges when performed at an Institute of Excellence, some services are only covered if the Transplant is received from an Institute of Excellence Hospital/Provider. **Please read each section below carefully.**

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to You in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Once it has been determined that You or one of Your eligible Dependents may require an organ transplant, You or Your Physician should call the Medical Management Program Administrator to discuss coordination of Your transplant care. Aetna will coordinate all transplant services. In addition, You must follow any preauthorization requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure You require. Please read each section below carefully.

<u>One Transplant Occurrence</u>

The following are considered one transplant occurrence:

- Heart.
- Lung.
- Heart/Lung.
- Simultaneous Pancreas Kidney (SPK).
- Pancreas.
- Kidney.
- Liver.
- Intestine.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant Surgery.
- Tandem transplants (stem cell).
- Sequential transplants.
- Re-transplant of same organ type within 180 days of first transplant.

- Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence

The following are considered more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).
- Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant Surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations

Transplant coverage does not include charges for the following:

- Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

- Distance requirement. The IOE facility must be more than 100 miles away from the patient’s residence.
- Travel allowances. Travel is reimbursed between the patient’s home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.
- Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.
- Overall maximum. Travel and lodging reimbursements are limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.
- Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, 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 private room charge. See Schedule of Benefits for any additional coverage of non Medically Necessary private rooms.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.

SECTION XII: Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Summary Plan Description for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health condition comparable to other similar Hospital, medical and surgical coverage provided under this Summary Plan Description. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
   - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
   - A state or local government run psychiatric inpatient Facility;
   - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
   - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;
   - and, in other states, to similarly licensed or certified Facilities.

   We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Public Health Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **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, mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

3. **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, or 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.

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

   ii. **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. 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.

      We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement 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 do not Cover delivery or service charges or routine maintenance.

- **iii.** **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 a licensed or certified applied behavior analysis Health Care Professional. "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.

- **iv.** **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 New York Insurance Law, licensed in the state in which they are practicing.

- **v.** **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 Summary Plan Description. 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 Summary Plan Description.

- **vi.** **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 New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Summary Plan Description.

- **vii.** **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Summary Plan Description 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 Copayment, Deductible or Coinsurance provisions under this Summary Plan Description for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit.

See the Schedule of Benefits section of this Summary Plan Description for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorders. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial Hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also Cover outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Summary Plan Description that covers the person receiving, or in need of, treatment for substance use disorder. 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.

SECTION XIII: Prescription Drug Coverage

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

A. Covered Prescription Drugs.

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease- specific treatment regimen. Specific diseases and disorders include but are 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. Multiple food allergies include, but are not limited to: immunoglobulin E and non-immunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered

under the infertility treatment benefit, including in vitro fertilization, in the Outpatient and Professional Services section of this Summary Plan Description.

- 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
- (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the- counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.jefflewishealth.com. You may inquire if a specific drug is Covered under this Summary Plan Description by contacting the number on Your ID card.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) 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 section of this Summary Plan Description.

C. Benefit and Payment Information.

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

   You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 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 Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.
     (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

     In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.
     (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

     To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

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

     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 Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

     You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting by calling the number on Your ID card.

5. **Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year, or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our 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 or is being removed from Our Formulary, We will notify You at least 30 days before the change is effective. When such changes occur, Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Summary Plan Description. You may access the most up to date tier status on Our website at www.jefflewishealth.com or by calling the number on Your ID card.

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

Please note, if You are taking a Brand-Name Drug that is being excluded or placed on a higher tier due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Summary Plan Description.

7. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Summary Plan Description. Visit Our website at www.jefflewishealth.com or call the number on Your ID card to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

8. **Supply Limits.** Except for contraceptive drugs or devices, We will pay for no more than a 90-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for up to a 90-day supply. You are responsible for the Copay amount listed in the Schedule of Benefits.

   You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two (2) Cost- Sharing amount[s] for a 90-day supply.

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 assessing Our website or by calling the 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 the Utilization Review and External Appeal sections of this Summary Plan Description.

9. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

10. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Summary Plan Description.

D. Medical Management.

This Summary Plan Description 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, ask Your Provider to complete a Preauthorization form. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.express-scripts.com or call the 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 for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, Including if a Prescription Drug or related item on the list is not Covered under Your Summary Plan Description. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Document.

3. **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 number on Your ID card.

E. 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 do not 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 (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding.

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 Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

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

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 the Outpatient and Professional Services section of this Summary Plan Description.

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

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

9. 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.

10. 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 the Utilization Review and External Appeal sections of this Summary Plan Description.

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

F. 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. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Summary Plan Description).

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

2. **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.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Summary Plan Description. This list is subject to Our periodic review and modification (generally quarterly, but no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug. To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.jefflewishealth.com or by call the number on Your ID card.

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

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

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

7. **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
    - Been designated by Us as a Participating Pharmacy.
      A Participating Pharmacy can be either a retail or mail-order pharmacy.

8. **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 and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies; as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Summary Plan Description 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.

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

11. **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 New York Education Law Section 6826- a.

SECTION XIV: Exclusions and Limitations

No coverage is available under this Summary Plan Description for the following:

A. 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.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or 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.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, 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 Summary Plan Description. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., 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 the Utilization Review and External Appeal sections of this Summary Plan Description unless medical information is submitted.

E. 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, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Summary Plan Description.

G. Experimental or Investigational Treatment.
We do not Cover any treatment, procedures, devices, drugs, or medicines which are determined to be Experimental and/or Investigational. However, We will Cover off-label drug use or when such expenses are considered qualified clinical trial expenses.

H. 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 or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. 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.

K. Medically Necessary.
In general, We will not Cover any Expenses which are determined not to be Medically Necessary.

L. 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). If You are covered on the Plan as a retiree, when You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

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

N. 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.

O. 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.

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

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

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses.

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

T. 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.

SECTION XV: Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Summary Plan Description. 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. See the Coordination of Benefits section of this Summary Plan Description for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. 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 at www.meritain.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Summary Plan Description. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Summary Plan Description.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment by June 30th of the year following the calendar year (180 days after the end of the Plan Year) in which You received the services for which payment is being requested. If it is not reasonably possible to submit a claim within that time period, You must submit it as soon as reasonably possible.

D. 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 Section 238-a(1) of the New York Public Health Law.

E. 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 contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Summary Plan Description.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Summary Plan Description.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., 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.

2. **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 (3) 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 period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. 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 deny the claim in whole or in part. 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 if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XVI: Utilization Review

A. 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. 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 the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent 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 (3) business days of receipt of the request.

   If We need additional information, We will request it within three (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 (3) 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 earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **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 be provided within three (3) business days of receipt of the request. 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 (or Your designee) 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 period.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, 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 notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent Reviews.

1. **Non-Urgent 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) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) 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) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **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 (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. 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 written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

4. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

5. **Inpatient Substance Use Disorder Treatment at Participating OASAS- Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost- Sharing that would otherwise apply to Your inpatient admission.

6. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider 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 and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested 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.

E. 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.

F. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

- You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. High Cost Drug Management
The primary objective of the High Cost Drug Management program is to provide assistance when You or eligible Dependents have been prescribed a high cost drug that exceeds $2,000 per month and is covered under the medical benefits section of the Plan.

The High Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost effective method.

If You or Your eligible Dependents are not currently utilizing the most cost effective method, the case manager will make a recommendation to how to obtain the medication from the most cost efficient Participating Provider. The program includes 1-on-1 coaching based on Plan provisions, support and education to improve adherence and avoid complications.

This is a voluntary service. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or comply with recommendations or suggestion provided by case managers.

H. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) 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.

I. 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 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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of- network service would likely not be substantially increased over the in- network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of- network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

J. First Level Appeal.

1. **Preauthorization 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 (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** 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 (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review 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, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   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 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external Appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external Appeal is pending.

K. Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

L. 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 (4) 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 inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization 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 (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** 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 (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

M. Appeal Assistance.
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

COMMUNITY HEALTH ADVOCATES 633 THIRD AVENUE, 10TH FL
NEW YORK, NY 10017

Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XVIII: External Appeal

A. External Review of Adverse Benefit Determinations

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

The Plan will provide for an external review process in accordance with federal law.

Note that the federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

1. An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer;

2. A rescission of coverage;

3. An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions;

4. An adverse determination involving whether a Covered Person is entitled to a reasonable alternative standard for a reward under the Plan’s wellness program (if any); and

5. An adverse determination involving whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations (if applicable and which generally require, among other things, parity in the application of medical management techniques).

For any adverse determination for which external review is available, the federal external review requirements are as follows:

You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

Within 5 business days following the date the Plan receives your external review request the Claims Fiduciary will complete a preliminary review. The Claims Fiduciary will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

1. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

2. If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

Within 5 business days following the date the Plan receives your external review request the Claims Fiduciary will complete a preliminary review. The Claims Fiduciary will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

1. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

2. If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

Following the Claims Fiduciary’s preliminary review, if the request is eligible for external review, the Claims Fiduciary will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Claims Fiduciary will forward to the IRO all information and materials relevant to the final internal adverse determination.

The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Claims Fiduciary. The Claims Fiduciary, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Claims Fiduciary will not delay the external review process. If the Claims Fiduciary does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO’s notice is required to contain the following:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

6. A statement that judicial review may be available to you; and

7. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

B. Expedited External Review

You may request an expedited external review if you have received:

An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:
Immediately following the date, the Claims Fiduciary receives the external review request the Claims Fiduciary will complete a preliminary review. The Claims Fiduciary will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

1. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

2. If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

Following the Claims Fiduciary's preliminary review, if the request is eligible for external review, the Claims Fiduciary will assign an independent review organization (IRO) to make a determination on the request for external review. The Claims Fiduciary will promptly forward to the IRO, by any available expeditious method (e.g., telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

The IRO must provide notice to the claimant and the Claims Fiduciary (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Claims Fiduciary. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;
6. A statement that judicial review may be available to you; and
7. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

C. Effect of External Review Determination

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

D. State Insurance Laws

Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

E. Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Claims Fiduciary has been rendered (or deemed rendered).

SECTION XIX: 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 coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"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.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
   - 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.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - 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 insurance coverage.

3. **"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).

4. **"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.

B. 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 Summary Plan Description 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 will 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:

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

C. 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.

D. 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.

E. 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.

F. Coordination with "Always Excess," "Always Secondary," or "Non- Complying" Plans.
Except as described below, 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 Summary Plan Description is primary, as defined in this section, We will pay benefits first.

2. If this Summary Plan Description 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 Summary Plan Description provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Summary Plan Description is primary.

SECTION XX: Termination of Coverage

Coverage under this Summary Plan Description will automatically be terminated on the first of the following to apply:

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 on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.

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

5. For Children, until the end of the month in which the Child turns 26 years of age.

6. For all other Dependents, the day in which the Dependent ceases to be eligible.

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

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or 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 and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Summary Plan Description. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. If We decide to stop offering all Hospital, surgical and medical expense coverage in the large 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. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

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

See the Continuation of Coverage section of this Summary Plan Description for Your right to continuation of this coverage.

SECTION XXI: Extension Of Benefits

When Your coverage under this Summary Plan Description ends, benefits stop. But, if You are totally disabled on the date the agreement terminates, or on the date Your coverage under this Summary Plan Description 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.

A. When You May Continue Benefits.

When Your coverage under this Summary Plan Description 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.

B. 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); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.

We will not pay extended benefits:

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

SECTION XXII: 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.

A. Qualifying Events.

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 Summary Plan Description 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:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Divorce or legal separation from the Subscriber; or
   - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Loss of covered Child status under the plan rules; or
   - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group 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.

The Group may 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 the Subscriber's 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 Subscriber, divorce or legal separation, the Subscriber'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; or
5. The date to which Premiums are paid if You fail to make a timely payment;

B. 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 (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Summary Plan Description will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group 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 Summary Plan Description 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 (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Policy 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 continuation 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).

The Subscriber's 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 Group or the Group's designee receives notice and We receive Premium payment; or
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 Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Summary Plan Description. The Child's children are not eligible for coverage under this option.

SECTION XXIII: 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 Summary Plan Description 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 Summary Plan Description or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Summary Plan Description to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Summary Plan Description for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void and unenforceable.

Assignment means the transfer to another person or to an organization of Your right to the services provided under this Summary Plan Description or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits.
Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Summary Plan Description.
We may unilaterally change this Summary Plan Description upon renewal, if We give the Group 30 days' prior written notice.

4. Choice of Law.
This Summary Plan Description shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Summary Plan Description, or any other documentation issued by Us in connection with this Summary Plan Description, 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. Conformity with Law.
Any term of this Summary Plan Description which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Summary Plan Description 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.

8. Entire Agreement.
This Summary Plan Description, including any endorsements, riders and the attached applications, if any, constitutes the entire Summary Plan Description.

9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
The Group and all persons covered under this Summary Plan Description will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Summary Plan Description. You must provide Us with information over the telephone for reasons such as 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 Group 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 Group's New York office.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Summary Plan Description. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

12. 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.

13. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by submitting a written request to the board of trustees.

14. Material Accessibility.
We will give Your ID cards, Summary Plan Descriptions, riders and other necessary materials.

15. More Information about Your Health Plan.

You can request additional information about Your coverage under this Summary Plan Description. 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 Summary Plan Description.
- 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 participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Summary Plan Description.

16. Notice.

Any notice that We give You under this Summary Plan Description will be mailed to Your address as it appears in Our records. 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: Your employer.

17. Premium Refund.

We will give any refund of Premiums, if due, to the Group.

18. 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.

19. Renewal Date.
The renewal date for this Summary Plan Description is the anniversary of the effective date of the Policy of each year. This Summary Plan Description will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Summary Plan Description or upon 30 days' prior written notice to Us.

20. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Summary Plan Description. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Summary Plan Description. 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 Summary Plan Description.

21. 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 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.

22. Severability.
The unenforceability or invalidity of any provision of this Summary Plan Description shall not affect the validity and enforceability of the remainder of this Summary Plan Description.

23. 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 Summary Plan Description. 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 Section 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.

24. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Summary Plan Description and nothing in this Summary Plan Description shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Summary Plan Description. No other party can enforce this Summary Plan Description's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Summary Plan Description, or to bring an action or pursuit for the breach of any terms of this Summary Plan Description.

25. 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 Summary Plan Description. You must start any lawsuit against Us under this Summary Plan Description within two (2) years from the date the claim was required to be filed.

26. Translation Services.
Translation services are available free of charge under this Summary Plan Description for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

27. Waiver.
The waiver by any party of any breach of any provision of this Summary Plan Description 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.

28. Who May Change this Summary Plan Description.
This Summary Plan Description may not be modified, amended, or changed, except in writing and signed by Our Plan Manager or a person designated by the Plan Manager. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Summary Plan Description in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the Plan Manager or person designated by the Plan Manager.

29. Who Receives Payment under this Summary Plan Description.
Payments under this Summary Plan Description 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 the Subscriber or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Summary Plan Description for more information about surprise bills.

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

31. Your Medical Records and Reports.
In order to provide Your coverage under this Summary Plan Description, 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 Summary Plan Description, except as prohibited by state or federal law, 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, to the extent permitted under state or federal law, 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 Summary Plan Description, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

32. Your Rights.
You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

SECTION XXIV: Schedule of Benefits

JEFFERSON-LEWIS ET. AL. SCHOOL - TRADITIONAL PLAN

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family **Medical Out-of-Pocket Limit** • Individual • Family (Includes Medical Deductible, Coinsurance and Copayments)	$322 $966 $1,288 $3,863	$322 $966 $1,288 $3,863	Any charges of a Non- Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount. See the Cost-Sharing Expenses and Allowed Amount section of this [Certificate; Contract; Policy] for a description of how We calculate the Allowed Amount.
Total Overall Medical and Prescription Drug Out-of-Pocket Limit • Individual • Family (Includes Deductible, Coinsurance and Copayments – combined with Prescription Drug Out-of-Pocket Maximum)	$7,350 $14,700	$7,350 $14,700	

OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits • Office or Clinic	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description Services outside the office visit charge: 20% Coinsurance after Deductible.
• Home	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	

Specialist Office Visits			
• Office or Clinic	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Services outside the office visit charge: 20% Coinsurance after Deductible.
• Home	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
• Outpatient Consultation	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Second Opinion Consultation	Covered in full	Covered in full	
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Covered in full	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Covered in full	
• Adult Immunizations*	Covered in full	Covered in full	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	
• Sterilization Procedures for Women*	Covered in full	Covered in full	
• Vasectomy	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	
• Bone Density Testing*	Covered in full	Covered in full	

• Screening for Prostate Cancer • Performed in PCP Office • Performed in Specialist Office	Covered in full Covered in full	Covered in full Covered in full	
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	The first $50 per trip: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Paid at the Participating Provider level of benefits	See benefit for description
Non-Emergency Ambulance Services	The first $50 per trip: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $50 per trip: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
Emergency Department – Emergency Medical Emergency Services Non-Emergency Services	Covered in full 20% Coinsurance after Deductible Health care forensic examinations (i.e., rape kits) performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Paid at the Participating Provider level of benefits 20% Coinsurance after Deductible Health care forensic examinations (i.e., rape kits) performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description

Urgent Care Center • Facility Charges • Physician Charges	Covered in full The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Covered in full The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services • Interpretations	Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
Preauthorization recommended for PET scans, capsule endoscopy and non-orthopedic CT and MRI’s.			
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	The first $80 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. The first $80 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $80 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. The first $80 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
Ambulatory Surgical Center Facility Fee	Covered in full	Covered in full	See benefit for description
Refer to Surgical Procedures benefit for Preauthorization recommendations for Surgeries.			

Anesthesia Services (all settings) • Specific Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.
• All Other Surgical Procedures	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	See benefit for description
Refer to Surgical Procedures benefit for Preauthorization recommendations for Surgeries.			
Autologous Blood Banking	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	 20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	80 visits per Plan Year (combined yearly limit - includes cardiac and pulmonary rehabilitation and speech and occupational therapy)
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed at Home	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Preauthorization recommended for Chemotherapy and oncology related injections, infusions and treatments, excluding supportive drugs (i.e. antiemetic and antihistamine).			

Chiropractic Services • Office Visit • Other Services	 The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. 20% Coinsurance after Deductible	 The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. 20% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Interpretations	 Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	 Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	

Habilitation Services (Physical, Speech or Occupational therapy) • Performed in an Office • Performed in Outpatient Facility	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	80 visits per Plan Year - combined limit that includes speech and occupational therapy, and cardiac and pulmonary rehab (also combined with rehabilitation services). Physical therapy does not apply to this yearly limit.
Home Health Care	Covered in full	Covered in full	80 visits per Plan Year
Preauthorization recommended for Home Health Care.			
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Limited to 3 cycles per lifetime. See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Preauthorization recommended for Infusion therapy for drugs costing over $2,000 per drug per month.			

Inpatient Medical Visits (including Inpatient Mental Health &/or Substance Use Professional Services)			See benefit for description
• Days 1-59	The first $25 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $25 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
• Days 60-365	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
• Multiple Visits Per Day and/or Over 365 days	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Consultations	The first $50 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $50 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
• Additional Inpatient Consultations Same Specialty, Same Confinement	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Interruption of Pregnancy			Unlimited
• Medically Necessary Abortions	Use Cost-Sharing for appropriate service (Surgery & Anesthesia)	Use Cost-Sharing for appropriate service (Surgery & Anesthesia)	
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	Covered in full	Covered in full	
• Performed in a Specialist Office	Covered in full	Covered in full	
• Performed in a Freestanding Laboratory Facility	Covered in full	Covered in full	

• Performed as Outpatient Hospital Services • Interpretations	Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
Preauthorization recommended for genetic testing (including BRCA testing).			

Maternity and Newborn Care
 	
• Prenatal Care
  • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
 	
  • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
	Covered in full
	
	Covered in full
		Covered in full
		
		Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
			See benefit for description

• Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full Use Cost-Sharing for appropriate service (Surgery & Anesthesia) Covered in full	Covered in full Use Cost-Sharing for appropriate service (Surgery & Anesthesia) Covered in full	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

• Postnatal Care	Covered in full	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	
Preauthorization recommended for inpatient Hospital and Birthing Center services			
Outpatient Hospital Surgery Facility Charge	Covered in full	Covered in full	See benefit for description
Refer to Surgical Procedures benefit for Preauthorization recommendations for Surgeries.			
Preadmission Testing • Interpretations	Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
Prescription Drugs Administered in Office • Performed in a PCP Office • Performed in Specialist Office	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Preauthorization recommended for drugs costing over $2,000 per drug per month.			
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed in Outpatient Facilities • Interpretations	 Covered in full Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	 Covered in full Covered in full Covered in full Covered in full The first $35 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description

Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Facility Services	 Covered in full Covered in full Covered in full	 Covered in full Covered in full Covered in full	See benefit for description
Preauthorization recommended for radiation therapy (therapeutic radiology services).			
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in an Office • Performed in an Outpatient Facility	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	80 visits per Plan Year - combined limit that includes speech and occupational therapy and cardiac and pulmonary rehab (also combined with habilitation services). Physical therapy does not apply to this yearly limit.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Covered in full	Covered in full	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • Inpatient Hospital Surgery:			See benefit for description
• Specific Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.
• All Other Surgical Procedures (except Transplants)	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	

• Transplants	Covered in full (Aetna IOE Providers)* Covered in full (All Other Network Providers)	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	*Please refer to the Institute of Excellence (IOE) Program item under Inpatient Services section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible. **NOTE:** Cornea transplants will be paid the same as any other Illness and are not considered under the transplant benefit or subject to IOE guidelines.
• Outpatient Hospital Surgery • Specified Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.
• Other Surgical Procedures	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	

• Surgery Performed at an Ambulatory Surgical Center • Specified Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.
• Other Surgical Procedures	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	
• Office Surgery • Specified Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.
• Other Surgical Procedures	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	
• Assistant Surgeon • Specified Surgical Procedures	Covered in full	Covered in full	See benefit for description of Specific Surgical Procedures.

• Other Surgical Procedures	Covered in full	If provider accepts negotiated rate: Covered in full If unable to receive negotiated rate: Covered in full up to the Usual, Customary and Reasonable (UCR) Charge; any amounts over the UCR: 20% Coinsurance after Deductible	
Preauthorization recommended for the following Surgical Procedures: • Breast and bone marrow biopsy • Thyroidectomy, partial or complete • Open prostatectomy • Oophorectomy, unilateral and bilateral • Back Surgeries and hardware related to Surgery • Osteochondral Allograft, knee • Hysterectomy (including prophylactic) • Autologous chondrocyte implantation, Carticel • Transplants (excluding cornea) • Balloon sinuplasty • Sleep apnea related Surgeries, limited to: o Radiofrequency ablation (Coblation, Somnoplasty) o Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures			
Telehealth Services (with Your Primary Care Physician, Specialist, and/or Mental Health and/or Substance Use Provider	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	The first $10 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible.	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin	20% Coinsurance after Deductible; Insulin see the Prescription Drug Cost-Sharing	20% Coinsurance after Deductible; Insulin see the Prescription Drug Cost-Sharing	See Prescription Drug benefit
• Diabetic Education	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.			

External Hearing Aids	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Limit one per ear every three (3) Plan Years
Cochlear Implants	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Hospice Care • Inpatient • Outpatient	 Covered in full Covered in full	 Covered in full Covered in full	210 days per Plan Year. Five (5) visits for family bereavement counseling
Medical Supplies	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	Unlimited; See benefit for description
Hyperbaric Oxygen Treatment	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Preauthorization recommended for hyperbaric oxygen treatment.			
Sleep Studies	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Preauthorization recommended for sleep studies.			

INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	The first 365 days per admission are Covered in full. Any days over 365 days 20% Coinsurance after Deductible. End of Life Care Covered in full.	The first 365 days per admission are Covered in full. Any days over 365 days 20% Coinsurance after Deductible. End of Life Care Covered in full.	* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. You will pay 20% Coinsurance after Deductible for the additional cost of a private room (costs exceeding the Semi-Private Room Rate) that is not Medically Necessary (i.e. You choose or request a private room for privacy reasons), limited to $10 per day.
Preauthorization recommended for all Inpatient stays/charges. However, Preauthorization is not needed for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.			
Observation Stay	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	Covered in full	Covered in full	100 days per Plan Year
Preauthorization recommended for all Inpatient stays/charges.			
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	Covered in full	Covered in full	100 days per Plan Year.
Preauthorization recommended for all Inpatient stays/charges.			

Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Covered in full	Covered in full	100 days per Plan Year.
Preauthorization recommended for all Inpatient stays/charges.			
Outpatient Hospital Facility Charges (non-surgical)	Covered in full	Covered in full	
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
When a Covered Person is obtaining treatment at an opioid treatment program all copayments will be waived during the course of such treatment.			
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) Refer to Inpatient Medical Visits for Inpatient Mental Health professional services.	The first 365 days per admission are Covered in full. Any days over 365 days 20% Coinsurance after Deductible.	The first 365 days per admission are Covered in full. Any days over 365 days 20% Coinsurance after Deductible.	* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. You will pay 20% Coinsurance after Deductible for the additional cost of a private room (costs exceeding the Semi-Private Room Rate) that is not Medically Necessary (i.e. You choose or request a private room for privacy reasons), limited to $10 per day.
Preauthorization recommended for all Inpatient stays/charges. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH licensed Facilities for Members under 18.			

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. Covered in full	The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. Covered in full	See benefit for description
ABA Treatment for Autism Spectrum Disorder	Use Cost-Sharing for appropriate Mental Health service	Use Cost-Sharing for appropriate Mental Health service	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment, not subject to Deductible	$25 Copayment, not subject to Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) Refer to Inpatient Medical Visits for Inpatient Substance Use professional services.	365 days Covered in full. Over 365 days 20% Coinsurance after Deductible.	365 days Covered in full. Over 365 days 20% Coinsurance after Deductible.	* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. You will pay 20% Coinsurance after Deductible for the additional cost of a private room (costs exceeding the Semi-Private Room Rate) that is not Medically Necessary (i.e. You choose or request a private room for privacy reasons), limited to $10 per day.
Preauthorization recommended for all Inpatient stays/charges. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH- licensed Facilities for Members under 18.			

Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services	 The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. Covered in full	 The first $8 per visit: covered in full. Remaining balance: 20% Coinsurance after Deductible. Covered in full	Unlimited visits may be used for family counseling
Teladoc Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
General Medicine	$10 Copayment, not subject to Deductible	Not Applicable	See benefit for description
Behavioral Health	$10 Copayment, not subject to Deductible	Not Applicable	
Dermatology	$10 Copayment, not subject to Deductible	Not Applicable	

PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
*Certain Prescription Drugs are not subject to Cost- Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy.			
Prescription Drug Out-of-Pocket Limit • Individual • Family (Includes Medical Deductible, Coinsurance and Copayments)	$6,062 $10,837	Not Applicable Not Applicable	Non-Participating Provider services are not Covered and You pay the full cost
Total Overall Medical and Prescription Drug Out-of-Pocket Limit • Individual • Family (Includes Deductible, Coinsurance and Copayments – combined with Prescription Drug Out-of-Pocket Maximum)	$7,350 $14,700	Not Applicable Not Applicable	Non-Participating Provider services are not Covered and You pay the full cost

Retail Pharmacy	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
30-day supply: Generic Preferred Brand Name Non-Preferred Brand Name Preauthorization is not required for Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	$15 Copayment $30 Copayment $60 Copayment Visit Our website at www.jefflewishealth.com or call the number on Your ID card to find out if a particular Prescription Drug is on the preventive drug list.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
A Covered Person may immediately obtain an additional 30-day supply of any current prescription, except scheduled II and III controlled substances, upon the declaration of a state disaster emergency.			
Up to a 60-day supply: Generic Preferred Brand Name Non-Preferred Brand Name	$30 Copayment $60 Copayment $120 Copayment Visit Our website at www.jefflewishealth.com or call the number on Your ID card to find out if a particular Prescription Drug is on the preventive drug list.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Up to a 90-day supply: Generic Preferred Brand Name Non-Preferred Brand Name	 $45 Copayment $90 Copayment $180 Copayment Visit Our website at www.jefflewishealth.com or call the number on Your ID card to find out if a particular Prescription Drug is on the preventive drug list.	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
A Covered Person may immediately obtain an additional 30-day supply of any current prescription, except scheduled II and III controlled substances, upon the declaration of a state disaster emergency.			
Mail Order Pharmacy			
Up to a 90-day supply Generic Preferred Brand Name Non-Preferred Brand Name	 $30 Copayment $60 Copayment $95 Copayment Visit Our website at www.jefflewishealth.com or call the number on Your ID card to find out if a particular Prescription Drug is on the preventive drug list.	 Non-Participating Provider services are not Covered and You pay the full cost	 See benefit for description

Enteral Formulas			
Generic	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preferred Brand Name	$30 Copayment		
Non-Preferred Brand Name	$60 Copayment		
Mandatory Specialty Pharmacy Program: 30-day supply			
Specialty Drugs not available through SaveOnSP	Paid the same as any other generic, preferred or non-preferred brand drug	Specialty Drugs obtained outside of SaveOnSP and/or the Mandatory Specialty Pharmacy Program offered through Express Scripts are not covered and You pay the full cost	A list of SaveOn Specialty Program Drugs may be found at Our website at www.jefflewishealth.com
Specialty Drugs received through SaveOnSP	$0 Copayment		
Specialty Drugs available through SaveOnSP but not obtained through SaveOnSP	30% Copayment		

Manufacturer Copay Assistance Program (MCAP): Prescription Drug assistance through SaveOnSP is offered as part of your Plan's Prescription Drug Card Program benefit. Utilizing copay assistance programs may reduce your Out-of-Pocket costs for certain Specialty Drugs. You must enroll in the SaveOnSP Program to be eligible to receive copay assistance if available. Please contact SaveOnSP at 1-800-683-1074, a patient advocate will assist you with completing your enrollment. Manufacturer assistance coupons applying to a Copay or Coinsurance responsibility will be credited towards your Deductible or Out-of-Pocket Maximum.

Coupons and Other Financial Assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your In-Network Out-of-Pocket Limit.

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and 3) all Generic Drugs.

SECTION XXV: RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

Issued by

JEFFERSON-LEWIS ET. AL. SCHOOL

Rider to Extend Coverage for Young Adults through Age 29

This rider, which has been selected by the Group, extends the eligibility of Children for coverage under Your Summary Plan Description and any applicable rider(s) thereto.

A. Young Adults Covered through Age 29.
If You selected parent and child/children or family coverage, Your young adult Child will be eligible for coverage until the day the Child turns 30 years of age, when the young adult:

1. Is unmarried;
2. 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; and
3. 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 under this rider.

The young adult's children are not eligible for coverage under this rider. Coverage under this rider terminates the day the Child turns 30 years of age.

B. Controlling Summary Plan Description.
All of the terms, conditions, limitations, and Exclusions of Your Summary Plan Description to which this rider is attached shall also apply to this rider except where specifically changed by this rider.