
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN

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Claims Administrator
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INTRODUCTION

This document is a description of Suffolk School Employees Health Plan (the Plan). No oral interpretations can change this Plan.

The goal of the Board of Trustees of the Suffolk School Employees Health Plan has been to provide you with a complete health benefits package at the lowest possible cost. A number of features have been included in the Suffolk School Employees Health Plan to manage costs and to ensure that the health care you receive is that which is the most appropriate for you.

This Summary Plan Description, which is also your Certificate of Benefits, describes in detail the health benefits coverage provided by the Suffolk School Employees Health Plan. The Plan is coordinated by United Healthcare and includes the following basic elements of coverage:

- **Hospitalization and Medical Coverage**
- **Prescription Drug Coverage for both Retail and Mail Order**

You should familiarize yourself with the Suffolk School Employees Health Plan by reading this Summary Plan Description so that you will be able to use the benefits it provides most effectively.

Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy the waiting period and all the eligibility requirements of the Plan.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, prior notification requirements, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Claims Administrator.

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

If the Plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to covered charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered employees and their dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Coordination with Medicare. Shows the Plan payment order when a person is covered under Medicare.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a covered person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

In its sole discretion, the Claims Administrator shall resolve all questions concerning the administration, interpretation or application of this Plan, subject to appeal to the Board of Trustees.

NEED HELP? – HERE ARE THE ADDRESSES AND PHONE NUMBERS YOU NEED

If you want information about any aspect of the Suffolk School Employees Health Plan, or if you need assistance in resolving a problem, you should first contact your District’s Benefits Administrator. The District’s Benefits Administrator can assist you in obtaining full information concerning your personal enrollment status as well as the eligibility requirements and benefit provisions of all enrollment options. Your District’s Benefits Administrator can also assist you in resolving any claims problems you may encounter.

You Have Questions About the Suffolk School Employees Health Plan:

- You have questions concerning your family’s eligibility for health coverage
- You have questions about changing your type of coverage (family/individual)
- Your employee benefit identification cards are lost or damaged
- You or a dependent did not receive your employee benefit identification card
- You want to know how to coordinate your Suffolk School Employee Health Plan benefits with Medicare
- You want to cancel your coverage
- Your home address changes

QUESTIONS ABOUT	CONTACT/ADDRESS	PHONE NUMBERS
<ul style="list-style-type: none"> • Enrollment • Eligibility 	Call the District’s Benefits Administrator for your school district. Sayville UFSD South Country Schools Three Village Schools Smithtown	 (631) 244-6538 (631) 730-1551 (631) 730-4034 (631) 382-2175
<ul style="list-style-type: none"> • Benefits Management • Benefits Questions • ID Cards • Pre-Admission Certification • Second Surgical Opinion • Out-patient Mental Health, Alcoholism and Substance Abuse Program • Mastectomy Second Medical Opinion Program • Managed Physical Medicine Program • Hospitalization • Preferred Provider Network or to order a Network Provider Directory • Medical Claims 	United Healthcare PO Box 740800 Atlanta, GA 30374-0800 www.myuhc.com/ssehpn	1(866) 844-4864
Retiree and COBRA Direct Billing	United Healthcare PO Box 740800 Atlanta, GA 30374-0800	1(866) 844-4864

GENERAL INFORMATION

WHO IS ELIGIBLE?

This section explains eligibility requirements under the Suffolk School Employees Health Plan for you (the enrollee) and your dependents. The Suffolk School Employees Health Plan has established minimum eligibility requirements, which must be met by all employees of districts that participate in the Suffolk School Employees Health Plan. However, your employer may have adopted modified rules. Please check with your personnel or business office.

MINIMUM REQUIREMENTS FOR ELIGIBILITY:

To be eligible for coverage, an employee must:

- (1) Be expected to work at least the minimum period of anticipated employment required by your district, and
- (2) Work a regular schedule of 20 hours or more a week, **OR**
- (3) Be in one of the following categories:
 - (a) An elected member of a school board for whom the Board of Education has authorized participation in the Plan.
 - (b) Be paid an annual salary at a rate of \$2,000 or more per year, **OR**
 - (c) Receive your major source of family income from employment with the employer.
- (4) Not already enrolled in the Suffolk School Employees Health Plan as an employee of another participating district, which is part of this Plan. Depending upon your district's contractual agreements, you may be eligible for family coverage if you are enrolled under the program as a dependent in another participating district that is part of the Suffolk School Employees Health Plan. Please check with your District's Benefits Administrator.

Note: These minimum requirements may be modified.

YOUR DEPENDENTS:

The following dependents are eligible for Suffolk School Employees Health Plan coverage:

- (1) *Your spouse, including a legally separated spouse, is eligible.* If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.
- (2) *Domestic Partner.* Subject to agreement by collective bargaining within each district.
- (3) *Your unmarried children under 19 years of age are eligible.* This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren.

If you apply for coverage on behalf of a dependent whose last name is different from yours or who is other than your spouse or own child, you must complete a Statement of Dependence Form and submit it to your district office for approval.

- (4) *Your unmarried dependent children who are age 19 or older but under age 25 are eligible if they receive more than half of their support from you, and are **full-time** students at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage.* They continue to be eligible for coverage through the month in which they complete course requirements for graduation. For children other than your natural

children, legally adopted children or stepchildren, who are supported by you as described in paragraph 2 above, your support must have commenced before the child reached age 19.

If your child reaches age 19 during a school vacation period, coverage will continue, as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period.

We require that a student affidavit be completed once per year. This requirement applies to all full-time students between the ages of 19 and 25.

Medical Leave for Students Over 19: If your covered child who is age 19 or older is granted a medical leave by an accredited secondary or preparatory school, college or other educational institution, coverage may continue for a maximum period of 12 calendar months following the month in which the child withdraws from school. If the end of the 12 calendar months occurs during a vacation period, coverage will be extended to the beginning of the next semester or trimester. You must be able to provide written documentation, including medical records, from the school and/or the physician if requested by the Claims Administrator.

Military Service: For purposes of eligibility for health coverage as a student dependent, you may deduct up to four years from your dependent's age for service in a branch of the U.S. Military.

(5) *Certain students completing graduation requirements:* Your unmarried dependent children who are age 19 or older but under age 25 who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

- (a) Otherwise qualify, **AND**
- (b) Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed, **AND**
- (c) Be able to provide the Suffolk School Employees Health Plan with a statement from their school or college administrator which verifies their status as a student.

If all of the above criteria are met, the students will continue to be eligible through the end of the month in which they complete course requirements for graduation. Coverage will not be extended beyond this semester unless full-time student status is resumed.

(6) *Disabled Dependents:* Your unmarried children age 19 or over who are incapable of supporting themselves because of a mental or physical disability acquired before termination of your child's eligibility for health coverage are eligible. For example, if your child becomes disabled after age 19 while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

If you have a child who qualifies for coverage as a disabled dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file a Disabled Dependent Form. Contact your District's Benefits Administrator several months before your child's 19th birthday.

If your child is covered as a full-time student between the ages of 19 and 25, and becomes disabled while in that status, you should file a Disabled Dependent Form at the time the disability occurs.

If you have any questions concerning eligibility, please contact your District's Benefits Administrator.

DISQUALIFICATION PROVISION

The Plan reserves the right to pursue legal action against a covered individual suspected of fraud, deception, false statements of a material fact, or accepting benefits for himself, herself, or a dependent knowing he/she or such dependent was not entitled to such benefits. Reimbursement to the Plan by a covered individual of benefits obtained improperly fraudulently, or by deceit, shall not waive the right of the Plan to pursue legal action against said individual.

GENERAL FRAUD PROVISION

Stop Health Care Fraud!

Fraud increases the cost of health care of everyone and increases your Health Benefit Plan contributions. All allegations of fraud, waste, and abuse in the Plan will be investigated.

Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized Plan representative. Let only the appropriate medical professionals review your medical record or recommend services. Report fraud to the Claims Administrator.

ENROLLMENT

HOW TO ENROLL: Enrollment is NOT automatic. YOU MUST APPLY. Benefits will not be payable unless you enroll.

If you are eligible for Suffolk School Employees Health Plan and you decide you want to be covered under the Plan, you must sign up for coverage. You will not be covered automatically.

To enroll for coverage, contact your District's Benefits Administrator.

If you or a dependent that you wish to enroll is already covered by another group insurance plan, you must complete Coordination of Benefits Form in addition to the enrollment form.

WHEN COVERAGE BEGINS: Your district establishes the date on which an employee becomes eligible for coverage.

HOW CHANGES IN YOUR STATUS AFFECT COVERAGE

Special circumstances, such as changes in your payroll status, may affect your enrollment. You need to make sure that your health coverage is correct. Consult the District's Benefits Administrator when your work or payroll status changes.

LEAVE WITHOUT PAY:

Continuing Coverage When on Leave: If you are on authorized **Leave Without Pay**, or otherwise leave the payroll temporarily, you may be eligible to continue your health coverage while you are off of the payroll.

COVERAGE WHILE YOU ARE ON LEAVE IS NOT AUTOMATIC. You must arrange for it with the District's Benefits Administrator before you go on leave.

Cost: To continue your health coverage, you must pay both the employee and employer share of the premium. The district will notify you of the cost and the due date for the payments. If you do not make your payments on time, your coverage will be cancelled and you will not be offered continuation of coverage privileges.

If you become disabled while you are on leave, you may be eligible for a waiver of premium. See the section entitled Waiver of Premium Provisions.

Suspending Coverage While Off of the Payroll: You may suspend your health coverage for the time you are on Leave Without Pay. Arrange for the suspension with your District's Benefits Administrator BEFORE your last

day of work. You will not be required to submit any premium payments. Your coverage will end on the last day of the month in which you request suspension.

Cancellation for Non-Payment of Premium: If you do not voluntarily cancel your health coverage and you do not make premium payments, your health coverage will be cancelled at the end of the month for which payments have been made.

Reinstatement after Cancellation - If your insurance is cancelled for non-payment of premium, you may appeal to the Board of Trustees for reinstatement. Reinstatement is at the sole discretion of the Trustees.

Consider the Consequences: Canceling your coverage or letting it lapse because you don't pay the premium has serious consequences. If you resign, vest, or retire while your coverage is cancelled, you and your dependents have no rights to coverage under the Suffolk School Employees Health Plan. If you pre-decease your dependents and you had cancelled your coverage or let it lapse, your dependents have no rights to coverage as dependent survivors.

You May Re-Enroll Before You Return To Work: If your coverage was suspended while you were on leave, you may re-enroll in the Suffolk School Employees Health Plan when you return to work, provided you still meet the eligibility requirements. Contact the District's Benefits Administrator to reactivate your coverage. Be sure to ask when your coverage will begin.

Please check with your school district office for eligibility information. If a waiting period is required by the school district, there is no coverage until such waiting period has been met.

HOW TO CANCEL ENROLLMENT:

To cancel your enrollment in the Suffolk School Employees Health Plan or to cancel coverage for a dependent, see your District's Benefits Administrator to complete the necessary form.

COVERAGE: INDIVIDUAL OR FAMILY

Two types of coverage are available to you under the Suffolk School Employees Health Plan:

INDIVIDUAL COVERAGE provides benefits for you only. It does not cover your dependents (your spouse or children) even if they are eligible for coverage.

FAMILY COVERAGE provides benefits for you and your eligible dependents. To enroll yourself and your dependents in family coverage, you must provide each person's date of birth and other information to the Suffolk School Employees Health Plan through your District's Benefits Administrator.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE:

If you qualify for a change from individual to family coverage and you want family coverage, contact your District's Benefits Administrator. This would apply to a change in family status or a loss of spouse's coverage.

You may need to change to family coverage as a result of one of the following events:

- (1) You acquire a new dependent (for example, you marry or have or adopt a child), **OR**
- (2) Your spouse's other health insurance coverage ends.

When Your Family Coverage Begins: The date your family coverage begins will depend on your **reason** for changing and your **promptness** in applying. You can avoid a waiting period by applying promptly.

Written proof of the event must be submitted to your District's Benefits Administrator.

Your new coverage begins:

- (1) If you apply on or before the date of the event, your family coverage will be effective on the date of the event.
- (2) If you apply within one month after the event, there will be a waiting period. Your family coverage will become effective on the first day of the month following your application.
- (3) If you apply more than one month after the event, there will be a longer waiting period. Your family coverage will become effective on the first day of the third month following the month in which you apply.

You must apply within one month of the event in order to avoid a three-month waiting period.

Considered late if previously eligible: If you change to family coverage in order to include your spouse or dependents who were **previously eligible** but not enrolled, their coverage will begin on the first day of the third month following the month in which you apply.

No coverage during the waiting period: Services received or expenses incurred by your dependent (s) during the waiting period will not be covered.

The effective date of coverage depends upon the reason for the change and the prompt notification to the Plan of such change.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE:

You must change to individual coverage when you no longer have **any** eligible dependents.

You may choose to change your coverage from family to individual at any time if you no longer wish to cover your dependents, even though they are still eligible.

Contact your District's Benefits Administrator for information about when your dependents' coverage ends if you change from family to individual coverage.

WAIVER OF PREMIUM

THREE REQUIREMENTS: In certain situations, you may be entitled to have your Suffolk School Employees Health Plan contribution waived for up to one year.

To qualify for a waiver of your Suffolk School Employees Health Plan premium, you must meet **ALL THREE** of the following requirements:

- (1) You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of three months.
- (2) You must be on authorized Leave Without Pay. You are **NOT** eligible for the waiver if you are still receiving income through salary, sick leave accruals or retirement allowance.
- (3) You kept your coverage in effect while you were off the payroll by paying the required full cost of your health benefit premium (your contribution and your District's contribution, if any) if you are on an approved leave without pay.

Waiver is NOT Automatic: A waiver of premium is **NOT** automatic. You must apply for it, and you must continue to pay your health benefit premiums until you are notified that the waiver has been granted. You will receive a refund for any overpayment.

Waiver Ends if: The waiver may continue for up to one year during your period of total disability **UNLESS:**

- (1) you return to the payroll
- (2) You are no longer on a Preferred List
- (3) you are no longer disabled
- (4) you are no longer a district employee (and are not on a preferred list)
- (5) you vest your health coverage rights
- (6) you retire
- (7) you die

HOW TO APPLY FOR A WAIVER OF PREMIUM: To apply for a waiver of premium, obtain a Waiver Form from your District's Benefits Administrator. After you, your district and your physician have filled in the required information, return the completed form to the school district benefit office.

YOU MUST APPLY DURING THE PERIOD IN WHICH YOU MEET THE ELIGIBILITY REQUIREMENTS FOR A WAIVER; you may NOT apply after you return to the payroll or vest or retire.

LAYOFF AND PREFERRED LIST:

If you are laid off and your name has been placed on a Department of Civil Service Preferred Eligible List, you may be able to continue your health coverage for a limited period of time. Contact your District's Benefits Administrator for information on whether your district offers this optional program feature.

CONTINUING COVERAGE WHEN YOU RETIRE OR VEST

Most districts permit enrollees who have met certain eligibility requirements to continue their coverage after retirement and may require you to contribute to the cost of such coverage. These requirements vary from district to district. **You should contact your District's Benefits Administrator for specific details of the rules of your employer.** The following information may be used as a general guideline.

ELIGIBILITY FOR RETIREE COVERAGE:

At the time of retirement, you must meet these minimum eligibility requirements in order to continue your health coverage:

- (1) If your district was covered with the previous health Plan (New York State Health Insurance Plan) before March 1, 1972 and you were hired before April 1, 1975, you may be eligible to continue coverage after retirement if you have completed five years of service with your district and are either qualified for retirement as a member of a retirement system coordinated by New York State (such as the New York State Teachers' Retirement System or the New York State Employees Retirement System), **OR**

If you are not a member of such a retirement system and are at least 55 years of age and if last entry into service was PRIOR TO September 1, 1983, OR you are 62 years of age and if last entry occurred ON OR AFTER September 1, 1983, you may also be eligible for retiree coverage, **AND**
- (2) You must be enrolled in the Suffolk School Employees Health Plan as an enrollee or a dependent at the time of your retirement. For example, if you were on leave and canceled your coverage and then retired, you would not be eligible for health insurance in retirement.

These provisions do not apply to all districts included in the Suffolk School Employees Health Plan. Please contact your District's Benefits Administrator to determine your benefit coverage in retirement.

NOTE: Periods of less-than-full-time employment will be considered as full-time if you met the health coverage eligibility requirements.

After you retire, you may cancel coverage, then re-enroll. You will be subject to a waiting period before your coverage again becomes effective.

DISABILITY RETIREMENT:

In the case of an ordinary (not work-related) disability retirement, the age requirement is waived, but you must meet the minimum service requirement.

In the case of a disability retirement resulting from a work-related Illness or Injury, the age requirement and the minimum service requirement are waived. Check with your District's Benefits Administrator for further information.

SUMMARY:

Before You Retire:

- **Check the requirements for continuing your health benefits in retirement.**
- **If you are eligible to continue your health insurance benefits, ask your District's Benefits Administrator to update your enrollment information.**
- **Contact your Social Security Administration office two or three months before you or a Dependent turns 65 to find out about enrolling in Medicare.**
- **If you are moving, please notify your district office.**

VESTING:

If your employment with the participating district ends before you reach retirement age and you vest your retirement allowance, you may continue your health coverage while you are in vested status provided:

- (1) you have satisfied the minimum requirements established by law for vesting your retirement allowance; **AND**
- (2) you have met all the minimum requirements, except age, for continuation of health coverage in retirement at the time employment is terminated. In addition, the participating district, which has elected to continue coverage for its retirees, may require that you be within five years of retirement at the time you vest.

To continue coverage as a vestee, be sure to contact your District's Benefits Administrator to arrange for continuation.

What You Pay: If you choose to continue your coverage while in vested status, you are responsible for paying both the employer and employee shares of the health premium.

In no case may the value of sick leave credits be applied toward health premium costs either while you are in vested status or after you become eligible to retire. Each district, may, by contract, allow you to apply all or a part of the value of your sick leave credits toward your premium if you retire directly from active employment. Please check with your District's Benefits Administrator.

Coverage Ends Permanently if You do not Continue as a Vestee: If you are eligible to continue coverage during vested status, but you do not do so, or if you fail to make the required premium payments as a vestee, coverage for you and your dependents will be terminated **permanently**. You may not re-enroll as a vestee at a later date and you lose eligibility for coverage as a retiree.

Note: If you are a vestee and you have Suffolk School Employees Health Plan coverage as a dependent through your spouse, you do not have to continue your own enrollment while vested. You may re-establish your own enrollment at any time as long as you have not allowed your coverage to lapse.

COVERAGE FOR YOUR DEPENDENT SURVIVORS

Extended Benefits Period at No Cost: The Suffolk School Employees Health Plan protects your survivors if you should die. If you die while you are enrolled in the Suffolk School Employees Health Plan as a participating district employee, vestee, or retiree, your UNREMARIED enrolled spouse and enrolled dependent children will continue to receive coverage for an extended benefit period of three months following the month in which the enrollee's death occurred at no cost to the survivor(s). However, in no case will extended benefits continue more than three months following the month in which the enrollee dies.

If you die while you are enrolled in the Suffolk School Employees Health Plan your enrolled dependents will be eligible for continuation of coverage or conversion to a direct payment contract through the State Continuation Coverage Law or COBRA.

Coverage After the Extended Benefits Period Ends: Coverage can be extended beyond the extended benefits period at a cost to the enrollee. If you have completed 10 or more years of service, your UNREMARIED spouse and eligible dependent children will be allowed to continue their coverage under the Suffolk School Employees Health Plan after the extended benefit period ends.

If you die as a result of a work-related illness or injury, your survivors will be eligible to continue their Suffolk School Employees Health Plan coverage whether or not you have completed 10 years of service.

An eligible dependent survivor who wishes to continue coverage under the Suffolk School Employees Health Plan must apply for the coverage within 90 days of the death of the enrollee. No application made after this period of time may be accepted.

For information on the cost of dependent survivor coverage, contact your District's Benefits Administrator.

Coverage For Your Eligible Dependents if Your Spouse Loses Eligibility or Dies: If your surviving spouse dies, your other eligible dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. If they no longer meet these requirements, they may be eligible to enroll through the Consolidated Omnibus Reconciliation Act (COBRA).

If your survivor is eligible for dependent survivor coverage but chooses not to participate or fails to make the required payments, coverage will be terminated permanently. Your survivor may not re-enroll.

If Your Family is Not Eligible for Dependent Survivor Coverage: If your spouse and dependents are not eligible for survivor coverage under the Suffolk School Employees Health Plan, they may be eligible to continue their coverage in the Suffolk School Employees Health Plan for a limited time under COBRA. See your District's Benefits Administrator for further information.

CONTINUATION OF COVERAGE

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your District's Benefits Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.

- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.

- A Participant's ex-spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of employment, for any reason other than gross misconduct.
- B. A reduction in the Participant's hours of employment that causes the Participant to lose coverage under the Plan.

With respect to a Participant's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
- B. A reduction in the Participant's hours of employment that causes the dependent to lose coverage under the Plan.
- C. Death of the Participant.
- D. Divorce or legal separation of the Participant.
- E. Loss of eligibility by an Enrolled Dependent who is a child.
- F. Entitlement of the Participant to Medicare benefits.
- G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

1. Notification Requirements for Qualifying Event

The Participant or other Qualified Beneficiary must notify District's Benefits Administrator within 60 days of the latest of the following events:

The Participant's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.

The date the Qualified Beneficiary would lose coverage under the Plan.

The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the District's Benefits Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the District's Benefits Administrator of these events within the 60 day period, the District's Benefits Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the District's Benefits Administrator within 60 days of the birth or adoption of a child.

2. Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the District's Benefits Administrator as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to the District's Benefits Administrator at the address stated in General Plan Information in this Summary Plan Description. The contents of the notice must be such that the District's Benefits Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the District's Benefits Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the District's Benefits Administrator.

The Qualified Beneficiary's initial premium due to the District's Benefits Administrator must be paid on or before

the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the District's Benefits Administrator for additional information. The Participant must contact the District's Benefits Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
 - ◆ the determination of the disability; or
 - ◆ the date of the qualifying event; or
 - ◆ the date the Qualified Beneficiary would lose coverage under the Plan; and
 - ◆ in no event later than the end of the first eighteen months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the Participant's Medicare entitlement; or
 - Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:
- Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
 - ◆ the Participant's Medicare entitlement occurs within the eighteen month continuation period; and

- ◆ if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.
- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

COBRA AND MEDICARE

If you, your spouse or other dependents become eligible to receive primary Medicare benefits under the Federal program, you or your covered dependents must enroll in Medicare. If you do not, your benefits under the Suffolk School's Employees Health Plan will be drastically reduced. Note: If you are an active employee and your spouse is under age 65 and is disabled, your spouse is eligible for Medicare. However, in this specific circumstance, the Suffolk Schools Employees Health Plan will remain primary and your spouse's benefits will be paid under the Suffolk Schools Employees Health Plan. In this specific instance, up until your spouse turns 65, not enrolling in Medicare will not dramatically reduce your benefits.

KEEPING YOUR COVERAGE UP TO DATE

Changes in Your Enrollment Status: Changes in your family status make it necessary, or desirable, for you to change your type of coverage. Changes in coverage do not happen automatically. You must submit a form to the District's Benefits Administrator of any changes, such as:

Your Family Coverage:

- You marry or divorce
- You acquire a dependent
- You no longer have **any** eligible dependents
- You no longer wish to provide coverage for a dependent
- You have a disabled dependent
- You or a covered dependent become eligible for Medicare benefits, although under age 65, because of disability
- Your spouse dies
- Your dependent dies

Your Status Changes:

- You are going to retire from your district

- You are affected by a layoff
- You are going on leave without pay
- You want to continue your health coverage while in vested status
- You become disabled and want to apply for a Waiver of Premium
- You want to cancel your health coverage to obtain dependent status under your spouse's Suffolk School Employees Health Plan coverage

SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT	\$1,000,000 per Lifetime and \$1,000,000 annual	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	\$300
Maximum Per Family	N/A	\$900
COINSURANCE: the difference between the Reasonable and Customary Charge and the covered percentage under the non-network providers portion of this Plan.		
The Plan will pay the designated percentage of Covered Reasonable and Customary Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Reasonable and Customary Charges for the rest of the Calendar Year.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	N/A	\$1,500 (Deductible is NOT included)
COPAYMENT/COINSURANCE	Contracted Rate	(R&C = Reasonable and Customary)
Hospital services - Inpatient	\$100	\$100
Physician visits	\$18.00	80% of R&C after the deductible
Emergency Room Outpatient services	\$25.00	Same as Network •

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Room and Board and Ancillary (Prior Notification required for Non-Network benefits)	100% after copayment at the semiprivate room rate 365 days per spell of illness	Same as Network <ul style="list-style-type: none"> • Notify Care Coordination • Non-Network Services: • Please remember that you must notify Care Coordination as follows: <p>For elective admissions: five business days before admission.</p> <p>For non-elective admissions: within one business day or the same day of admission.</p> <p>For Emergency admissions: within 48 hours of admission, or as soon as is reasonably possible.</p>
Cancer Resource Services	100% A voluntary program that offers patients access to a network of facilities and providers that specialize in the treatment of cancer. Contact Member Services for further information.	Only available In Network
Skilled Nursing Facility (Prior Notification required for Non-Network benefits)	100% one-half Hospital average semiprivate room and board rate	100% one-half Hospital average semiprivate room and board rate <ul style="list-style-type: none"> • Notify Care Coordination • Non-Network Services: Please remember that you must notify Care Coordination as follows: <ul style="list-style-type: none"> • [REDACTED] <p>For elective admissions: five business days before admission.</p> <p>For non-elective admissions: within one business day or the same day of admission.</p> <ul style="list-style-type: none"> • For Emergency admissions: within 48 hours of admission, or as soon as is reasonably possible. • [REDACTED]

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Services		
Inpatient visits	100%	80% of R&C after the deductible
Office visits	100% after copayment	80% of R&C after the deductible
Home Health Care (Prior Notification required for Non-Network benefits)	100% <ul style="list-style-type: none"> Limited to \$150,000 Annual Maximum combined In and Out of Network. 	Same as Network (deductible waived). <ul style="list-style-type: none"> Limited to \$150,000 Annual Maximum combined In and Out of Network. Notify Care Coordination Please remember that for Non-Network Benefits you should notify Care Coordination five business days before receiving services.
Outpatient Private Duty Nursing	100%	80% of R&C after the deductible
Hospice Care (Prior Notification required for Non-Network benefits) Life expectancy of six months or less must be certified by Hospice Organization Network and Non-Network Benefits are unlimited.	100%	100% <ul style="list-style-type: none"> Notify Care Coordination Please remember that for Non-Network Benefits you should notify Care Coordination.
Bereavement Counseling	100%	100%
Ambulance Service	Ground Transportation 100% of first \$50.00 then 80% of R&C Air Transportation covered only for emergency transport to nearest hospital 100% of first \$50.00 then 80% of R&C	
Wig After Chemotherapy Limited to 1 per lifetime	100%	100% of R&C waive deductible
Occupational Therapy	100% after copayment	80% of R&C after the deductible
Speech Therapy	100% after copayment	80% of R&C after the deductible
Physical Therapy The duration and extent of the coverage will be determined by the plan subject to Care Coordination review	100% after copayment	80% of R&C after the deductible

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<p>Outpatient Surgery, Diagnostic and Therapeutic Services</p>	<p>100% for Outpatient Surgery, Diagnostic Services, Diagnostic Therapeutic Services –CT Scans, Pet Scans, MRI and Nuclear Medicine and Therapeutic Treatments</p> <p>\$35 copay for Laboratory Services at a Hospital.</p>	<p>80% of R&C after the deductible for Outpatient Surgery, Diagnostic Services, Diagnostic Therapeutic Services –CT Scans, Pet Scans, MRI and Nuclear Medicine and Therapeutic Treatments</p>
<p>Acupuncture Services</p>	<p>100% after copayment when performed by an MD only.</p>	<p>80% of R&C when performed by an MD only.</p>
<p>Dental Services – Accident Only Care must be rendered within 12 months of the injury) (Prior Notification required)</p> <ul style="list-style-type: none"> • Notify Care Coordination • Please remember that you must notify Care Coordination as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) • • 	<p>100% after copayment</p>	<p>80% of R&C after the deductible</p>
<p>Durable Medical Equipment (Prior Notification required for Non-Network Services)</p> <p>Network and Non-Network Benefits for Durable Medical Equipment have no annual maximum.</p>	<p>90%</p>	<p>80% of R&C after the deductible</p> <ul style="list-style-type: none"> • Notify Care Coordination • Please remember that for Non-Network Benefits you must notify Care Coordination before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). •
<p>Ostomy Supplies</p>	<p>90%</p>	<p>80% of R&C after the deductible</p>
<p>Prosthetics</p>	<p>100%</p>	<p>100% (deductible waived)</p>

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Orthotics (Preauthorization required for open cutting procedures only, otherwise orthotics are not covered. Only one orthotic per Calendar Year is covered)	100% after copayment	80% of R&C after the deductible up to \$275 per Calendar Year
Chiropractic Services <ul style="list-style-type: none"> • Benefits include diagnosis and related services and are limited to one visit and treatment per day. Duration of care is subject to review. • 	100% after copayment	80% of R&C after the deductible
Mental Health Disorders		
Inpatient (Prior Notification required)	100% after \$100 copayment	80% of R&C after the deductible <ul style="list-style-type: none"> • If you don't notify Care Coordination, Benefits will be reduced by \$200.
<ul style="list-style-type: none"> • Any combination of Network and Non-Network Benefits for inpatient Mental Health Services is limited to 30 days per calendar year. • 		
Outpatient (Prior Notification required)	100% after copayment	80% of R&C after the deductible <ul style="list-style-type: none"> • Any combination of Network and Non-Network Benefits for outpatient Mental Health Services is limited to 36 visits per calendar year
Substance Abuse Disorders		
Inpatient Rehab Residential Treatment is covered	100% after \$100 copayment	80% of R&C after the deductible <ul style="list-style-type: none"> • If you don't notify Care Coordination, Benefits will be reduced by \$200.
(Prior Notification required)	<ul style="list-style-type: none"> • Any combination of Network and Non-Network Benefits for inpatient Substance Abuse Services is limited to 30 days per calendar year. • 	
Outpatient (Prior Notification required)	100% after copayment	80% of R&C after the deductible <ul style="list-style-type: none"> • Any combination of Network and Non-Network Benefits for outpatient Substance Abuse Services is limited to 60 visits per calendar year.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care		
Routine Health Exams	100% after copayment	80% of R&C after deductible
Includes: office visits, pap smear, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, and immunizations/flu shots.		
Mammogram	100%	100%
Frequency limits for mammogram Ages 35 – 39..... single baseline Ages 40 and over..... annually		
Routine Well Newborn Care	100%	80% of R&C after the deductible
Routine Well Child Care	100%	80% of R&C after the deductible
Routine Adult Care (includes an annual exam and an annual ob-gyn exam)	100%	80% of R&C after the deductible
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, and immunizations..		
Organ Transplants (Donor coverage is available if the recipient is covered under the Plan)	Hospital - 100% Surgeon - 100% Network Benefits are available for transplants performed at United Resource Network (URN) Transplant Centers or at any United Healthcare Network Hospital. The URN includes medical centers of excellence that specialize in the transplant process You may contact Member Services for a listing of United Resource Network Transplant Centers and information on voluntary participation in the URN Transplant Program	Hospital – Same as Network Surgeon - 80% of R&C after the deductible • Notify Care Coordination • Non-Network Services:
Pregnancy	100% after copayment	80% of R&C after the deductible
Chemotherapy	100%	80% of R&C after the deductible
Radiation treatment	100%	80% of R&C after the deductible
Hemodialysis	100%	80% of R&C after the deductible

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Infertility Benefits	100% after copayment \$25,000 Lifetime maximum	80% of R&C after the deductible \$25,000 Lifetime maximum
Includes: In-vitro Fertilization and Artificial Insemination. Maximum Lifetime amount is combined for in and out-of-network. Medication covered via Pharmacy Benefit.		
Hearing Aid Coverage	Reimbursed up to \$1,200 maximum every 36 months. Includes examination for and fitting of hearing aids. Not subject to the copayment, deductible or coinsurance. Repairs not covered.	

PRESCRIPTION DRUG BENEFIT

Pharmacy Option

	<u>Network/Non-Network</u>	
	<u>Retail</u>	<u>Mail Order</u>
Tier 1 drugs		
Copayment.....	\$5.00	\$5.00
Tier 2 drugs		
Copayment.....	\$20.00	\$20.00
Tier 3 drugs		
Copayment.....	\$30.00	\$30.00

- **Note: If Generic is available, and member elects Brand, then the member pays the copayment plus the difference between the cost of Brand and Generic.**

- **Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Formulary Brand Name drugs and Tier 3 was previously referred to as Non-Formulary Brand Name Drugs**

Note: You will be responsible for the difference between the Predominant Reimbursement Rate and a Network Pharmacy’s Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product that was obtained at a Non-Network Pharmacy.

Retail Pharmacy coverage up to a 31-day supply.

Home Delivery coverage up to a 90-day supply.

Verification of Eligibility (866) 844-4864 through United Healthcare Pharmacy Services

MEDICAL BENEFITS

All benefits described in this section are subject to the exclusions and limitations described more fully herein including, but not limited to services, supplies and care that are not experimental and/or investigational. The meanings of these terms are in the Defined Terms section of this document. These benefits may change from time to time. Please be sure to read all Plan Bulletins for such changes as they occur.

In general, network providers are responsible for notifying United Healthcare before they provide certain services to you. However, there are certain situations in which you are responsible for calling United Healthcare. This is called Prior Notification.

Prior Notification is required for the services listed below.

- Chiropractic (after 15th visit)**
- Dental Services – Accidental Only**
- Durable Medical Equipment**
- Hospitalizations – Non-Emergency**
- Inpatient Substance Abuse/Mental Health Disorder treatments**
- Orthotics**
- Skilled Nursing Facility Admissions**
- Transplantation Services**

The Plan is a Choice Plus Plan with Network Providers.

Choice Plus name: United Healthcare Choice Plus Plan
Address: PO Box 740800
Atlanta, GA 30374-0800
Telephone: (866) 844-4864

This Plan has entered into an agreement with certain hospitals, physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Under the following circumstances, the higher in-network payment will be made for certain non-network services:

If a covered person is out of the Network service area and has a medical emergency requiring immediate care.

Additional information about this option, as well as a list of Network Choice Plus Plan Providers, will be given to plan participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the covered person must pay before the Plan pays.

A deductible is an amount of money that is paid once a calendar year per plan participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services rendered by Non-Network providers. Each January 1st, a new deductible amount is required.

A copayment is a smaller amount of money that is paid each time a particular service is rendered by Network providers. There may be copayments on some services while other services will not have any copayments.

• CANCER RESOURCE SERVICES (CRS)

- Access to the CRS Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in their specific cancer. Potential benefits include accurate diagnosis, appropriate therapy (neither too little nor too much), higher survival rates and decreased costs.
- Network benefits are available for patients who receive care at a designated Cancer Resource Services Network facility.
- Participation in this program is voluntary for the enrollee. To ensure network benefits are received under this program, patients, or someone on their behalf, must contact Cancer Resource Services at
- **1-866-936-6002** before receiving care. More information is also available at www.urncrs.com.
- Coverage for Clinical Trials at a Cancer Resource Services designated facility is not covered as part of this benefit.
- Travel and Lodging Assistance is available as part of the Cancer Resource Services program up to \$10,000 for travel and \$500 per diem, coverage for patient and one caregiver with a Lifetime Maximum of \$10,000.
- Specialized Cancer Case Management Services is covered as part of this benefit. If covered refer patient to
- **1-866-936-6002**

HOSPITALIZATION AND RELATED EXPENSE COVERAGE IN-PATIENT HOSPITAL CARE

Benefits will be provided for covered medical care when you are an in-patient in a hospital or birthing center as described below.

- (1) **In a Hospital:** The term "Hospital" means only an institution that fully meets every one of the following tests:
 - It is primarily engaged in providing on an in-patient basis, diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice; AND
 - It continuously provides 24-hours-a-day nursing service by or under the supervision of registered graduate nurses; AND,
 - It is not a skilled nursing facility and it is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

- (2) **Hospital Service Covered:** Benefits will usually be provided for all the diagnostic and therapeutic services provided the hospital. However, the services must be given by an employee of the hospital, the hospital must bill for the services, and the hospital must retain the money collected for the services.

As a registered bed patient in a hospital as defined above, or any general hospital located outside our operating area, you and your enrolled dependents are each eligible to receive the following benefits:

IN-PATIENT SERVICES:

Number of Days of Care: The Plan will provide up to 365 days of care for each spell of illness subject to a \$100 inpatient copayment per hospital admission. The days of care may be for in-patient hospital care, or maternity care in a birthing center. Please refer to page 17 in the Schedule of Benefits section. There is a limit of 30 days of care per calendar year for the treatment of mental or nervous conditions and 30 days per year for the treatment of substance abuse conditions.

A spell of illness begins when you are admitted to a hospital or birthing center.

The spell of illness ends when, for a period of at least 90 days, you have NOT been a patient in a hospital or birthing center.

Out-Patient Hospital Care and Hospice Care: Out-patient hospital care is provided whenever you meet the requirements. The 365-benefit-day limitation does not apply to out-patient hospital care. Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care.

BED, BOARD AND GENERAL NURSING CARE:

Semi-Private Accommodations: If you are a hospital patient in a semi-private room, your bed, board (including special diets) and general nursing care are covered in full for 365 days.

Private Accommodations: If you occupy a private room, you receive for the 365-day period a daily allowance equal to the hospital's average semi-private room charge toward the cost of the bed, board and general nursing care.

OTHER HOSPITAL SERVICES:

You are covered in full for the following services, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which you are hospitalized:

- Use of operating and recovery rooms and equipment
- Use of intensive care or special care units and equipment
- X-ray, laboratory and pathological examinations
- Use of cardiographic or endoscopic equipment and supplies
- Drugs and medicines for use in the hospital, which are commercially available for purchase and readily obtainable by the hospital
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee
- Sera, biologicals, vaccines and intravenous preparations
- Anesthesia supplies and use of anesthesia equipment
- Oxygen and other inhalation therapeutic service and supplies
- Dressings and plaster casts
- Physical and Occupational therapy and Rehabilitation service and supplies
- Radiation and nuclear therapy in a facility approved by the appropriate governmental authorities
- Any additional medical services and supplies customarily provided by participating hospitals, unless specifically excluded from the contract

MATERNITY CARE:

Maternity benefits are provided for expenses incurred in a hospital for all females enrolled through the Plan.

Regular hospital benefits will be provided for hospital stays involving any pregnancy-related condition, whether or not the pregnancy is terminated. Additionally, benefits for routine nursery care of the newborn child are provided during the mother's covered hospital stay.

Group health plans generally, may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

NEWBORN CHILDREN:

Benefits are available from birth for:

- (1) The treatment of illness or injury
- (2) **Routine newborn care**

Please note that you must notify your District's Benefits Coordinator within 30 days of the birth of a child and complete an enrollment form to ensure that the child is covered under the Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OUT-PATIENT SERVICES

You will be required to pay a co-payment per visit for some of the out-patient services listed below. Please note that you may be asked to make the co-payment at the time the service is given. However, if you are treated in the hospital's out-patient department, but are then admitted as an in-patient at that time, you will not have to pay this co-payment. A summary of the co-payments is listed in the Schedule of Benefits Section on pages 16-22.

(1) Emergency Services: We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider. See Defined Terms on page 41.

Emergency Care for an Accident: The first visit for treatment of an accidental injury within 72 hours following such injury.

Emergency Care for Sudden Onset of an Illness: The first visit for treatment within 24 hours of the onset of sudden or serious illness.

Some examples of emergencies include heart attack or suspected heart attack, uncontrolled bleeding, loss of consciousness, severe shortness of breath, poisoning, suspected overdose of medication, severe burns, fractures and high fever in infants.

(2) Minor Surgery: Subject to a co-payment per visit. Benefits for follow up care at the hospital such as suture removal and check-up visits will be provided for only when billed inclusive of the initial visit.

(3) Radiation Therapy

- (4) **Laboratory Tests:** Benefits for the use of a network hospital laboratory will be subject to a \$35 co-payment. Tests performed at network laboratory facilities will be paid at 100%. Tests at non-network lab facilities will be paid at 80% of R&C, after the deductible. Laboratory tests will be paid for, only if they are necessary for the treatment and diagnosis of your illness or injury, and they are ordered by your physician. You must be present at the out-patient department.
- (5) **Diagnostic X-rays:** Diagnostic X-rays will be paid for, only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your physician. You must be present at the out-patient department.
- (6) **Pre-surgical Testing:** Subject to a co-payment per visit. The following conditions must be met:
- The tests are ordered by a physician as a preliminary step in your admission to a hospital as a registered bed patient for surgery; **AND**
 - They are necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; **AND**
 - You have a reservation for the hospital bed and for the operating room before the tests are given; **AND**
 - You are physically present at the hospital when the tests are given; **AND**
 - Surgery actually takes place within 14 days after the tests are given.
- (7) **Out-patient Physical Therapy:** Benefits will be provided for physical therapy in an out-patient setting only when all of the following conditions are met:
- The treatments are ordered by your physician; **AND**
 - The treatments can be expected to improve the patient's condition
- (8) **Hemodialysis Treatment:** The treatments must be ordered by your physician.
- (9) **Chemotherapy:** Not subject to copayment. The treatment must be ordered by your physician. However, payment will not be made for:
- Oral chemotherapy; **OR**
 - Subcutaneous injection; **OR**
 - Intramuscular injection
- (10) **Mammography Screening:** Not subject to a co-payment. Mammography screening for occult breast cancer is covered as follows:
- Upon the recommendation of a physician, at any age for covered enrollees;
 - A single baseline mammogram for covered enrollees 35 – 39 years of age;
 - An annual mammogram for covered enrollees 40 year of age and older
 - Non-routine mammograms no age schedule applies
- (11) **Administration of Desferal for Treatment of Cooley's Anemia:** Subject to a co-payment per visit. Benefits will be provided for out-patient visits when it is ordered by a doctor and performed at a hospital qualified to provide this service as determined by the Plan.
- (12) **Psychiatric Care in a Day or Night Care Center:** Outpatient visits will be provided for care of mental or nervous conditions in a day or night care center of an acute general or public hospital. The following conditions must be met:
- The care must be in lieu of hospitalization; and
 - The patient must remain in the day or night care center for at least three hours; and
 - The program must be certified by the appropriate state agency, if the hospital is located in another state; or
 - The program must be certified in New York State according to the State's mental hygiene law.

HOME HEALTH CARE

Home care benefits are available under a physician-approved plan of treatment when the necessary services are rendered through a New York State certified home health care agency. The provider outside of New York State must be a hospital or non-profit public home health care service or agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required.

Covered Services Include:

- Part-Time Professional Nursing
- Part-Time Home Health Aide Services (Up to 4 hours of such care is equal to one home care visit.)
- Physical, Occupational or Speech Therapy
- Medical Supplies, Drugs and Medicines Prescribed By a Physician
- Necessary Laboratory Services

When home health care is provided through a certified agency, these additional services are covered:

- Medical Social Worker Visits
- X-Ray and EKG Services
- Ambulance or Ambulette to the hospital for needed care
- Limited to \$150,000 Annual Maximum combined In and Out of Network.

CARE IN SKILLED NURSING FACILITIES

Benefits are provided for covered services received in a skilled nursing facility if the patient is referred by a physician for rehabilitation treatment, and Prior Notification Requirements have been satisfied”

Coverage is available in institutions that are approved as skilled nursing facilities by Medicare, or the Joint Commission on Accreditation of Hospitals. However, no benefits will be provided in any institution (or the specialized division of such institution) that is used primarily as a rest facility, home for the aged, or a place for the treatment of drug addiction or alcoholism.

INPATIENT TREATMENT OF MENTAL HEALTH OR NERVOUS DISORDERS AND ALCOHOL OR SUBSTANCE ABUSE DISORDERS

- Any combination of Network and Non-Network Benefits for Inpatient Mental Health Services is limited to 30 days per calendar year:
- Any combination of Network and Non-Network Benefits for Inpatient Substance Abuse Services is limited to 30 days per calendar year:

Care may be rendered in:

- An acute care general hospital
- A psychiatric hospital licensed by the state in which it is located
- An inpatient Substance Abuse Facility licensed by the state in which it is located

OUTPATIENT TREATMENT OF MENTAL HEALTH OR NERVOUS DISORDERS AND ALCOHOL OR SUBSTANCE ABUSE DISORDERS

.Any combination of Network and Non-Network Benefits for Outpatient Mental Health Services is limited to 36 visits per calendar year.

Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to 60 visits per calendar year.

Within New York State, care for alcoholism is covered only at facilities certified by the New York State Division of Alcoholism and Alcohol Abuse. Care for substance abuse is covered at only facilities certified by the New York State Division of Substance Abuse Services.

Outside of New York State, care must be provided by a facility with a treatment program approved by the Joint Commission on Accreditation of Hospitals.

HOSPICE CARE

- Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care. Network and Non-Network Benefits are unlimited.

The covered member is covered for in-patient hospice care in a hospice or hospital, and home health care and out-patient services are provided by the hospice as described below if:

- The patient has been certified by his or her primary attending physician as having a life expectancy of six months or less;
- The hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law; or if the hospice is located outside of this state, under a similar certification process required by the state in which the hospice organization is located.

Typically, covered hospice and out-patient services include:

Bed patient care either in a designated hospice unit or in a regular bed, and day care services provided by the hospice organization.

Home care and out-patient services provided by the hospice and charged to you by the hospice are also covered. The services may include the following:

- Bereavement counseling for the member's family, before and until one year after the member's death.
- Drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental nature)
- Intermittent care by an RN, LPN or Home Health Aide
- Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control of symptoms
- Medical care provided by the hospice physician
- Medical supplies
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Respite care
- Social services
- Speech therapy

WORLDWIDE PROTECTION

Hospitalization benefits are provided anywhere in the world.

In-Patient Care: When you are admitted to any legally constituted general hospital; you receive the benefits described in this booklet.

Out-Patient Care: When you receive out-patient care for emergency illness or injury or use a hospital's facilities for a surgical operation, out-patient benefits are provided for such care.

If you are required to pay a bill for services provided under your contract, submit the itemized bill along with a claim form to the Claim Administrator and you will be reimbursed, according to the Plan's provisions.

Foreign International Claims are covered at the out of network level. Emergencies are covered at the network level.

NETWORK PROVIDER PROGRAM

The Network Provider Program option of the Plan is described in this section.

There is no cost to you for services or supplies when they are covered under a Network Provider Program, except for the co-payment. At the time services are sought, patients should always ask their provider if he or she is a participant in the Third Party Administrator's Network Provider Program.

The following covered medical services are included in the Plan Benefits. Charges for these services will be paid directly to the Provider you have chosen under the in-network benefit. Except for the co-payment, you do not pay these charges yourself – the program has been designed to make payment for you.

- (1) **Office and Home Visits:** You are covered for physicians' office visits and home visits by a physician for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-baby care. General medical care includes routine pediatrics and physical exams.
- (2) **In-Hospital Physician's Visits:** You are covered for physician's office visits while an in-patient in a hospital if such visits are not related to surgery. **Benefits related to surgery are included in the scheduled amount for the surgery.**
- (3) **Surgery:** You are covered for the services of physician for surgery, including post-operative care, whether performed in or out of a hospital. ***In the same visit, if you have an office visit charge and an office surgery charge, only ONE CO-PAYMENT will apply.***
 - (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based upon 100% of the Contracted Rate for the primary procedure and 50% of the Contracted Rate for all other procedures. Any procedure that would be an integral part of the primary procedure or that is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Contracted Rate for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Contracted Rate allowed for that procedure; and
 - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Contracted Rate allowance.

(iv) No balance billing when an in-network provider is used.

- (4) **In-Hospital Anesthesia:** You are covered for anesthesia services if such services are performed in connection with in-hospital and ambulatory surgery, maternity care or shock therapy.
- (5) **Maternity Care:** You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. Payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided.

Maternity care may be rendered by a physician or licensed or certified nurse-midwife. The nurse-midwife must be:

- A. Licensed or certified to practice nurse-midwifery, and
- B. Permitted to perform the service under the laws of the state where the services are rendered.

- (6) **Specialist Consultations:** Your physician may refer you to a specialist for a consultation. During the consultation, the specialist will evaluate your medical condition and give you and your physician professional advice on how to proceed with your care. This specialist may or may not be a Network Provider. If you wish to use a specialist who is an In-Network Provider, you should refer to the list of providers in your area. When you use an Out-of-Network Provider, benefits are payable under the Out-of-Network portion of this Plan.
- (7) **Diagnostic Laboratory and X-Ray Examinations:** You are covered for diagnostic laboratory and x-ray procedures performed out of a hospital. You are also covered for the separate interpretation of x-rays by a radiologist if the radiologist bills separately. If both diagnostic laboratory and diagnostic radiology procedures are charged by a In-Network Provider during an office visit only **ONE** co-payment will apply toward the office visit charge and **ONE** co-payment will apply toward diagnostic services.
- (8) **Chiropractors:** You are covered for visits to your chiropractor and also for necessary related x-rays. The extent of coverage will be determined by the Plan based on an ongoing review on a case-by-case basis. **Maintenance care is NOT covered.**
- (9) **Visiting Nurse Services:** You are covered for part-time or intermittent visits by participating nurses or by registered nurses from accredited participating nurses services. Care must be under the supervision of a physician.
- (10) **Orthotics:** Each claimant will be covered for only one orthotic claim during the calendar year, for open cutting procedures only. Charges will be reimbursed subject to the usual reasonable and customary guidelines. These benefits are subject to the deductible and coinsurance of the Plan.
- (11) **Podiatry:** You are covered for the services of a podiatrist except for routine care of the feet.
- (12) **Physiotherapy:** You are covered for the application of physio-treatment and/or treatment by osteopathic manipulation.
- (13) **Radiation Therapy:** You are covered for radiation therapy given in or out of a hospital.
- (14) **Shock Therapy:** You are covered for shock therapy treatments given in or out of a hospital.
- (15) **Physical Therapy:** You are covered for visits to a physical therapist when the services provided are prescribed by a physician. The extent of the coverage will be determined by the Plan based on an ongoing review.
- (16) **Oral and Injectable Substances:** The cost of oral and injectable substances for **routine preventative pediatric immunizations** will be a covered expense.

MAJOR MEDICAL/OUT-OF-NETWORK PROGRAM

If you incur covered medical expenses and do not use a Network Provider, your benefits will be determined under the Major Medical portion of this Plan. This segment describes your coverage under the Major Medical Expense Program, and how the program works.

Assignment of benefits to a non-network provider is permitted. Also, you are responsible for the changes billed and must submit a claim for benefits due. These benefits are calculated based on the following:

- (1) First, you are liable for the deductible. It is your responsibility.
- (2) After the deductible, covered medical expenses are considered for payment. In most instances, you will receive the set percentage identified in the Benefit Summary Section, usually 80% of the Reasonable and Customary expenses. You pay the remaining balance. This is called the co-insurance.

Details of the annual deductible and how it works, and your covered medical expenses, are described on the following pages. The dollar values maximum benefits, co-payments and deductibles as well as the co-insurance percentages are all identified in the Summary of Benefits Section on pages 16-22.

ANNUAL DEDUCTIBLE:

The annual deductible amount is \$300 for each covered person in each calendar year, except that:

- (1) The annual deductible amount in each calendar year shall not exceed \$900 for all the members of your family combined.
- (2) Only one deductible amount will apply to all covered medical expenses incurred by your family as a result of any one accident during the calendar year in which the accident occurs.

COVERAGE:

The Plan will pay Out-of-Network expense benefits to the extent covered medical expenses in a calendar year exceed the deductible and co-insurance.

COVERED OUT OF NETWORK EXPENSES:

Covered Out-of-Network expenses are defined as the Reasonable and Customary charges for covered medical services performed or supplies prescribed by a physician, except as otherwise provided, due to your sickness, injury or pregnancy. These services and supplies must be necessary in terms of generally accepted medical standards as determined by the Plan. No more than the Reasonable and Customary charge for medical services and supplies will be covered by this Plan.

◆
◆ You must notify the Claims Administrator before getting certain Covered Health Services from non-Network providers. Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

◆
◆ When you notify the Claims Administrator as described above, they will work with you to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Under the Major Medical Program, covered medical expenses include charges for the following services or supplies:

- (1) *Hospitals and Approved Facilities:*

- A. Services of hospitals for which hospitalization benefits are provided are covered excluding:
 - 1. Any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;
 - 2. Charges for out-patient services covered by your hospitalization;
 - 3. Services not billed for by the hospital.
- B. Services of private proprietary hospitals for the treatment of mental and nervous conditions and alcoholism are paid in full less the \$100 copayment, up to the contracted rate and within time limitations for in-network facilities. For out-of-network facilities in-patient psychiatric care charges are covered at 80% of the hospital's semi-private rate less the \$100 copayment, and within time limitations.

If a private room is used, room and board charges will be covered medical expenses only to the extent of the hospital's most common semi-private room rate.

REMEMBER: You must comply with the prior notification requirements for a hospital or approved facility admission.

- (2) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based upon 100% of the Reasonable and Customary allowance for the primary procedure and 50% of the Reasonable and Customary allowance for all other procedures. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Eligible Expense for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Eligible Expense percentage allowed for that procedure; and
 - (c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Eligible Expense.
- (3) *Physicians:* Services of physicians are covered, except that:
 - A. Services received on an in-patient basis for the treatment of mental and nervous conditions will be payable only during a period in which benefits are payable under the Plan for room and board;
 - B. Out-patient services for the treatment of mental and nervous conditions, will be payable as set forth in the "Mental Health" segment.
- (4) *Nursing Services:* Services of a nurse are covered provided such services at home are:
 - A. Prescribed by a physician; AND
 - B. Rendered by a registered professional nurse (R.N.); OR
 - C. Rendered by a licensed practical nurse (L.P.N.); AND
 - D. Not rendered by someone who lives in your home or by a member of your immediate family.

The following services are excluded; assistance with daily living, companionship or any other service that can be given by a less-skilled person, such as a home health aide. Please see the Home Health Care section of the SPD for limitations and exclusions.

The first 24 hours of such services in a calendar year are **NOT** a covered expense.

- (5) *Nurse-Midwife Services*: Maternity services of a nurse-midwife are covered if the nurse-midwife is:
- A. Licensed or certified to practice nurse-midwifery, AND
 - B. Permitted to perform the service under the laws of the state where the services are rendered.
- (6) *Chiropractors*: Services of a duly licensed chiropractor will be covered for:
- A. Manual manipulation of the spine to correct a subluxation that can be shown by X-ray; and
 - B. Other services prescribed by a physician, **EXCEPT maintenance care.**
- (7) *Podiatrists*: Services of duly licensed podiatrists for the treatment of:
- A. Diseases
 - B. Injuries
 - C. Malformation of the foot
- are covered, **EXCEPT** that those treatments or supplies that are listed as Exclusions under the Plan. The supplies covered under this benefit are subject to the Orthotics benefit parameters.
- (8) *Hearing Aids*: Hearing aids, including examinations for and the fitting of, are covered up to a total maximum reimbursement of \$1,200 in any 36-month period. These benefits are not subject to the deductible or co-insurance.
- (9) *Durable Medical Equipment*: The rental, or purchase when appropriate, of durable medical equipment is covered if such equipment is customarily used for therapy and suitable for home use. In the case of purchased equipment, coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.
- (10) *Prosthetics*: Artificial limbs or other prosthetic devices, including replacement when it is functionally necessary to do so, are covered.
- (11) *Ambulance Service* The following charges for ambulance services are covered medical expenses:
- A. 100% of first \$50 then 80% of Reasonable and Customary allowance for Ground Ambulance Transportation.
- (12) *Cardiac rehabilitation* as deemed necessary as determined by Care Coordination.
- (13) *Eye Care Following Cataract Surgery*: The charges for one set of prescription eyeglasses or contact lenses and one eye exam are covered medical expenses following cataract surgery.
- (14) *Voluntary Sterilization*: Charges for voluntary sterilization are covered medical expenses.
- (15) *Miscellaneous Services*: The following services are covered under the major medical program portion of the Plan.
- A. Diagnostic lab procedures and X-rays and X-ray or radiation treatments
 - B. Oxygen and its administration

- C. Anesthetics and their administration, oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions.
 - D. Blood transfusions, including the cost of blood and blood products; however, such costs will be covered medical expenses only to the extent that there is evidence, satisfactory to the Plan, that such supplies could not be obtained without cost.
 - E. Chemotherapy
 - F. Hemodialysis
- (16) *Professional Services For In-patient Psychiatric Care:* Services rendered by a physician for in-patient psychiatric care in a hospital will be paid at 80% of Reasonable and Customary charges after the annual deductible is met.
- (17) *Pre-Donation Of Blood:* The cost (Reasonable and Customary Allowance) to administer the pre-donation of blood prior to scheduled surgery will be a covered expense. A physician's statement will be required indicating that it was necessary, and the physician must state the quantity of blood to be donated. This expense will be subject to the deductible and co-insurance.
- (18) *Orthotics:* Each claimant will be covered for only one orthotics claim within 12 months of related surgery. For out-of-network benefits services charges will be reimbursed subject to the usual Reasonable and Customary guidelines, not to exceed \$275. These benefits are subject to the deductible and coinsurance of the Plan.
- (19) *Physical Therapists:* Services of a duly licensed physical therapist will be covered when those services are prescribed by a physician. The extent of coverage will be determined by the Plan based on an ongoing review.
- (20) *Private Duty Nursing Care.* The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
- (a) *Inpatient Nursing Care.* Charges are covered only when care is medically necessary or not custodial in nature.
 - (b) *Outpatient Nursing Care.* Charges are covered only when care is medically necessary and not custodial in nature. The only charges covered for outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.
- (21) *Home Health Care Services and Supplies.* Charges for home health care services and supplies are covered only for care and treatment of an injury or sickness when hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending physician and be contained in a Home Health Care Plan.
- Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.
- A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.
- (22) *Hospice Care Services and Supplies.* Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care services and supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered spouse and/or covered dependent children). Bereavement services must be furnished within one year after the patient's death.

(23) *Infertility.* In-Vitro fertilization and artificial insemination are covered up to a total of \$25,000 lifetime maximum. Coverage includes diagnostic testing treatments and procedures. This is a combined maximum with out-of-network coverage, subject to the copayment for in-network providers and subject to the deductible and coinsurance for out-of-network providers. Medication is covered through pharmacy benefits.

(24) *Injury to or care of mouth, teeth and gums.* Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under medical benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under medical benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(25) *Occupational therapy* by a licensed occupational therapist. Therapy must be ordered by a physician, result from an injury or sickness and improve a body function.

(26) *Organ transplant limits.* Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Covered Health Services for the following organ and tissue transplants when ordered by a Physician.

- Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:
- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.

- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

If the organ or tissue donor is a covered person under the Plan, and the recipient is not, then the Plan will not provide coverage for expenses incurred by the donor.

- (27)** *Reconstructive Surgery.* Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

This mammoplasty coverage will include reimbursement for:

- (a)** reconstruction of the breast on which a mastectomy has been performed,
- (b)** surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (c)** coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient.

- (28)** *Speech therapy* by a licensed speech therapist. Therapy must be ordered by a physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a sickness that is other than a learning or mental disorder.
- (29)** *Surgical dressings, splints, casts and other devices* used in the reduction of fractures and dislocations.
- (30)** Charges associated with the initial purchase of a *wig after chemotherapy*.

DEFINED TERMS

Active Employee is an Employee who is on the regular payroll of the employer and who has begun to perform the duties of his or her job with the employer on a full-time or part-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator – United Healthcare (including its affiliates) which provides certain claim administration services for the Plan.

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

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than 62 days:

A group health plan.

Health insurance coverage.

Medicare.

Medicaid.

Medical and dental care for members and certain former members of the uniformed services, and for their dependents.

A medical care program of the Indian Health Services Program or a tribal organization.

A state health benefits risk pool.

The Federal Employees Health Benefits Program.

Any public health benefit program provided by a state, county, or other political subdivision of a state.

A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person is an employee, retiree or dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-administered.

Dental Services – Accidental Only Dental services when treatment is necessary because of accidental damage.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health

Emergency Services. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

- The person's health, or, in the case of a behavioral condition, the person's health or the health of others; could reasonably be in danger;
- The person's bodily functions could be seriously impaired;
- One of the organs or other parts of the body could be seriously harmed; or
- The person could be seriously disfigured.

Employee means a person who is an active, regular employee of the employer, regularly scheduled to work for the employer in an employee/employer relationship or a retiree covered under the Plan. An independent contractor is not included in the definition of employee.

Employer is Suffolk School Employees Health Plan participating school districts.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Family Unit is the covered employee or retiree and the family members who are covered as dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered employee's; the child depends on the covered employee for primary support; the child lives in the home of the covered employee; and the covered employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate hospital unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

Illness means a bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a plan participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a special enrollment period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

Mammography Screening means an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

Maternity Services This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Medical Care Facility means a hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the covered person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotics are devices, appliances, or braces that straighten or re-shape a body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Pharmacy means a licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Suffolk School Employees Health Plan, which is a benefits plan for certain employees of school districts participating in the SSEHP Plan and is described in this document.

Plan Administrator – Suffolk School Employees Health Plan

Plan Participant is any employee, retiree or dependent who is covered under this Plan.

Plan Sponsor Suffolk School Employees Health Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Pregnancy is childbirth and conditions associated with pregnancy, including complications.

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

Inhalers (with spacers).

Insulin.

The following diabetic supplies:

- standard insulin syringes with needles;

- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices;
- glucose monitors.

Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

Retired Employee is a former active employee of the employer who was retired while employed by the employer under the formal written plan of the employer and elects to contribute to the Plan the contribution required from the retired employee's school district.

Sickness is a person's illness, disease or pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from injury or sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of mental disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SSEHP is the Plan Sponsor.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a dependent child, the complete inability as a result of injury or sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Services Health Services for organ and tissue transplants.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

This is not an all-inclusive listing. Please refer to other pertinent Sections in this document, when necessary.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Anesthesia.** Services or supplies for the administration of anesthesia, if the charges for surgery are not covered under this Plan.
- (2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (3) **Custodial care.** Payment will not be made for services rendered during a hospital stay or a portion of a hospital stay in connection with physical check-ups, convalescent, custodial or sanitarium-type care, rest cures and services or supplies rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility except as otherwise specifically covered under this Plan. The program provides benefits for the normal period of in-patient convalescence following surgery or other acute illness. However, when the purpose of admission is convalescent, custodial, or sanitarium-type, no benefits are available. In those instances where the type of care rendered during a continuous period of hospital confinement develops into convalescent, custodial, or sanitarium-type care, that portion of the stay beginning on the day of such development is excluded from benefits.

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

This section also excludes service in any nursing home except as provided in a Medicare-approved or J.C.A.H. approved skilled nursing facility for acute or skilled care that meets all contract guidelines and criteria, and home health care.

- (4) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (5) **Excess charges.** The part of an expense for care and treatment of an injury or sickness that is in excess of the Eligible charge.
- (6) **Exercise programs and Equipment.** Exercise programs and equipment for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (7) **Experimental, Investigational or Unproven Services.** Services or supplies, including any hospitalization, in connection with such technology which is considered to be experimental, investigative, obsolete or ineffective in terms of generally accepted medical standards as determined by the Plan in its sole discretion with the advice of the Board of Trustees of the Suffolk School's Employees Health Plan in appropriate cases.

"Experimental" or "investigational" means that the technology is:

- A. not of proven benefit for the particular diagnosis or treatment of the covered person's condition, OR
- b. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition.

We may apply any or all of the following five criteria at our discretion in determining whether a technology is experimental, investigational, obsolete or ineffective:

- a. Any medical device, drug or biological product must have received final approval to market by the US Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met.
 - b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.
 - c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that, over time, the technology leads to improvement in health outcomes, i.e, the beneficial effects outweigh any harmful effects.
 - d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.
 - e. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes (as defined in #c above) is possible in standard conditions of medical practice, outside clinical investigatory settings.
- (8) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (9) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (10) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.
- (11) **Hospital employees.** Professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility and paid by the hospital or facility for the service.
- (12) **Illegal drugs or medications.** Services, supplies, care or treatment to a covered person for injury or sickness resulting from that covered person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician. Expenses will be covered for injured covered persons other than the person using controlled substances and expenses will be covered for substance abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (13) **Legal actions or settlements.** Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you.
- (14) **Medical summaries/invoice preparations.** Services rendered for medical summaries and medical invoice preparations.
- (15) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

- (16) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (17) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a physician; or treatment, services or supplies when the covered person is not under the regular care of a physician, except for chiropractic services. Regular care means ongoing medical supervision or treatment, which is appropriate care for the injury or sickness.
- (18) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (19) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness. Morbid Obesity unless deemed necessary, subject to review by Care Coordination.
- (20) **Occupational.** Care and treatment of an injury or sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (21) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds, unless deemed medically necessary.
- (22) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (23) **Relative giving services.** Professional services performed by a person who ordinarily resides in the covered person's home or is related to the covered person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (24) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.
- (25) **Reversal of voluntary sterilization.** Reversal of voluntary sterilization and complications thereof.
- (26) **Routine sonograms.** Routine sonograms solely to determine the gender of a fetus.
- (27) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (28) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (29) **Sleep disorders.** Care and treatment for sleep disorders unless deemed necessary, subject to review by Care Coordination.
- (30) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.
- (31) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

- (32) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (33) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined as a covered expense.
- (34) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

SSEHP has entered into a contractual agreement with United Healthcare Pharmacy Services for coverage of prescription medication both for retail pharmacies and mail order pharmacy provider.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy prescription is limited to a 31-day supply or 120 quantity, whichever is less. Any one mail order prescription is limited to a 90-day supply or 360 quantity, whichever is less.

Note: If Generic is available and member elects Brand, then the member pays the copayment plus the difference between the cost of Brand and Generic.

When Coordinating Benefits with Another Plan

The prescription copayment amount is a covered charge under the Medical Plan for members whose Prescription Plans are primary to the Suffolk School Employees Health Plan Prescription Plan. Suffolk School Employees Health Plan members are then reimbursed at 100% of the copayment they paid with their primary insurance carrier. The following details the claim submission process:

Claim Submission Process:

- Step 1. Member goes to the pharmacy and uses their primary carrier's health plan card.
- Step 2. Member pays the primary carrier's copayment at the pharmacy and gets a receipt showing the amount paid.
- *Step 3. Member fills out a United Healthcare claim form and attaches the pharmacy receipt.
- Step 4. United Healthcare will process the claim and a check will be mailed to the member for full reimbursement.

*For accurate and expeditious claim processing, here are some helpful tips:

- Use one United Healthcare claim form per member.
- Only submit claims for dates of service on or after January 1, 2007.
- Please make sure that the pharmacy receipt is attached. Claims will not be processed without the receipt.
- Do not send prescription coordination of benefits claims to United Healthcare Pharmacy Services. Send them directly to:

**United Healthcare Insurance Company LLC
PO Box 740800
Atlanta, GA 30374-0800**

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer covered persons significant savings on their prescriptions.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, infertility drugs, impotence medication and growth hormones, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies (not covered under the medical supply benefit or DME benefit) when prescribed by a physician.

Limits To This Benefit

This benefit applies only when a covered person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a physician.
- (2) Refills up to one year from the date of order by a physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered prescription drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. These may be covered under the Durable Medical Equipment benefit.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the covered person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Immunization.** Immunization agents or biological sera. Please refer to medical benefits for coverage.
- (9) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (10) **Inpatient medication.** A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

- (13) **No charge.** A charge for prescription drugs that may be properly received without charge under local, state or federal programs.
- (14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the physician.
- (16) **Smoking cessation.** A charge for prescription drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator decides in its discretion that a Covered Person is entitled to them.

When a covered person has a claim to submit for payment that person must:

- (1) Obtain a claim form from the Personnel Office or the Claims Administrator.
- (2) Complete the employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the physician complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

United Healthcare Insurance Company LLC
P.O. Box 740800
Atlanta, GA 30374-0800

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator up to 90 days after the close of the Calendar Year. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time.
- (b) The person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a plan participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the plan participant with a written notice of this denial. This written notice will be provided within 45 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

- (d) appropriate information as to the steps to be taken if a plan participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the plan participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 45-day period.

CLAIMS REVIEW AND APPEALS PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the plan participant may appeal the denial. This appeal provision will allow the plan participant to:

- (a) Request from the Claims Administrator a review of any claim for benefits. Such request must include: the name of the employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The participant should submit any data or comments to support the appeal, as well as any data or information requested by the Claims Administrator.

The request for review must be directed to the Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the plan participant with a written response within 60 days of the date the Claims Administrator receives the plan participant's written request for review. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the plan participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the plan participant's written request for review. Where possible, the review will be conducted by an employee of the Claims Administrator who did not previously review the claim.

Final Level Appeals:

The final level of appeal is directly to the Plan. The member may address their appeal to:

United Healthcare Insurance Company LLC
ATTN: Suffolk School Employee Health Plan Appeals - SPOE Request
601 Brooker Creek Blvd
Oldsmar, FL 34677

This appeal should include a written explanation of the dispute and any supporting documentation, i.e. doctor's letter of medical necessity, and detail any extenuating circumstances. The appeal will be presented to the Appeals Committee of the Plan with all identifying information deleted. The Plan's Appeals Committee meets quarterly and presents appeals to the entire Board of Trustees. The determination of the Board of Trustees is final. The appellant will be notified of the Board's determination by the Claims Administrator.

The Claims Administrator's written response to the plan participant shall cite the specific Plan provision(s) upon which the denial is based.

Time Period for Final Level Appeals:

The final appeal must be filed within 180 days of the initial denial of the claim.

Filing a Suit for Benefits:

A plan participant must exhaust the claims appeal procedure before filing a suit for benefits.

Lawsuits to obtain benefits may not be commenced more than two (2) years following the date of denial of benefits.

Urgent Situations Requiring Expedited Appeals:

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations: The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent requests for Benefits appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan.

If the appeal is denied, a further appeal to the Board of Trustees may be initiated by the participant and decided by the Appeals Committee and Chairperson of the Board of Trustees. Expedited appeal determinations will be made within 10 business days based upon the information available to the Appeals Committee and the Chairperson. The parties will be notified of the final determination by the Claim's Administrator.

COORDINATION OF BENEFITS

If a covered person is entitled to benefits for medical care and/or prescription drug benefits under this Plan and at least one other plan, the amount of benefits provided by this Plan for that care, if this Plan is the Secondary Plan, may be reduced to the extent that the total benefits paid or provided by all plans are not more than the total of the allowable expenses that the person incurs. As each claim is submitted, the Secondary Plan determines its obligations to pay for the stated percentage of allowable expenses based on the expenses included in that claim.

“Plan”: This term means any plan that provides medical coverage written on an expense-incurred basis with which coordination is allowed.

- **“Plan”** may include:
 - (1) any group insurance, or any other method of coverage for persons in a group.
 - (2) an uninsured arrangement of group coverage.
 - (3) group coverage through HMOs and other prepayment, group practice and individual practice plans.
 - (4) any governmental plan, but not including a state plan under Medicaid.
 - (5) any plan required by law, but shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
 - (6) the medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.
- **“Plan”** shall NOT include:
 - (1) blanket school accident coverage; or
 - (2) hospital indemnity coverage.

“This Plan”: This term means that part of this Plan that provides benefits for medical care.

“Primary Plan”: This term means this Plan, or any other plan, which determines its medical benefits for a covered person without taking into account any other plan. A plan is primary if either:

- (1) the plan does not have a Coordination of Benefits provision like this Plan; **OR**
- (2) the plan, in accord with Order of Payment, would determine its benefits first.

“Secondary Plan”: This term means any plan which is not a Primary Plan.

“Medicare”: This term means TITLE XVIII of the Federal Social Security Act, as it now is, or as it may be changed.

A person who is eligible for Medicare will be deemed to have all the coverage for which he or she is so eligible.

“No-Fault Motor Vehicle Plan”: This term means a motor vehicle plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault.

A person subject to such law who has not complied with the law will be deemed to have received the benefits required by law.

“Order of Payment”: When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

- (1) A plan, which does not have a provision like this Coordination of Benefits, will pay before this Plan.
- (2) A plan, which covers a person other than as a dependent, will pay before a plan that covers a person as a dependent.
- (3) A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year; provided that:
 - (a) If said dates of birth are the same, the plan that has covered a person for the longest time will pay first.
 - (b) if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefit.

In this Clause 3, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

- (a) first, the plan of the parent with custody of the child;
- (b) then, the plan of the spouse of the parent with custody of the child;
- (c) finally, the plan of the parent not having custody of the child.

However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Claim Determination Period of a plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

- (4) The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that person’s dependent) are determined before those of a plan which covers such person as a laid-off or retired employee (or as that person’s dependent) or a person covered under another plan as an active employee.
- (5) If the above four rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first. The length of time a person has been covered under a plan is determined by the following:
 - (a) Two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
 - (b) The claimant’s length of time covered under a plan is measured from the claimant’s first date of coverage under that plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

To process claims, the Coordinator, without the consent of any person, will have the right:

- (1) To give or to get any data needed to determine benefits under this provision; and each person claiming benefits under a plan must give the Coordinator any data needed to pay the claim.
- (2) To pay an organization for the payment made under its plan, which should have been paid by the Coordinator. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan. The term “**payment made**” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.
- (3) To recover any excess if the amount paid is more than it should have paid under this provision from one or more of:
 - (a) the persons it has paid or for whom it has paid;
 - (b) insurance companies; or
 - (c) other organizations.

COORDINATING YOUR SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN BENEFITS WITH MEDICARE

MEDICARE: A FEDERAL PROGRAM:

Medicare is a Federal health insurance program for people age 65 or older, certain disabled persons, or those who have End-Stage Renal Disease (permanent kidney failure). It is coordinated by the Federal Health Care Financing Administration. Local Social Security Administration offices take applications for Medicare and provide information about the program.

Medicare has three parts: **Part A (Hospital insurance)** which can help pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care; **Part B (medical insurance)** which can help pay for necessary physicians' services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare; and **Medicare Advantage Part C**, if you have Medicare Parts A and B, you can join a Medicare Advantage (formerly Medicare + Choice) plan.

PRIMARY COVERAGE:

A health plan provides "primary coverage" when it is responsible for paying health benefits before any other group is liable for payment.

If you, your spouse or other dependents become eligible to receive primary Medicare benefits under the Federal program, you or your covered dependents **MUST** enroll in Medicare. **If you do not, your benefits under the Suffolk School Employees Health Plan will be drastically reduced.**

WHEN THE SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN PAYS FIRST:

The Suffolk School Employees Health Plan will automatically provide primary coverage for an Active Employee, regardless of age, and for the Employee's enrolled Dependents. For those who are eligible for Medicare due to permanent kidney failure, the Suffolk School Employees Health Plan is primary for generally the first 30 months of treatment, then Medicare becomes primary.

The Suffolk School Employees Health Plan also will automatically provide primary coverage for eligible retired Employees, their Spouses, and other enrolled eligible Dependents who are under age 65 and are not disabled.

WHEN MEDICARE PAYS FIRST:

Medicare is primary for retired employees age 65 or older, and/or their spouses age 65 or older. In some cases, Medicare is also primary for employees under age 65 who are disabled. ***If the Social Security Administration determines that you and/or your Spouse are disabled, you or your Spouse will be eligible for primary Medicare coverage after two years. The Plan remains primary for the two year Waiting Period.***

For end-stage renal disease: Under certain circumstances, you, your spouse or other covered dependents are eligible for primary Medicare coverage. Medicare imposes a three-month waiting period at the onset of end-stage renal disease (permanent kidney failure) before Medicare becomes effective unless you have enrolled in a self-dialysis training program within the first three months of your diagnosis of end-stage renal disease, or receive a kidney transplant within three months of being hospitalized for the transplant.

If there is a waiting period, the insurer that provided primary benefits before the start of end-stage renal disease will remain the primary insurer for the three-month waiting period. That insurer will then be the primary insurer for the next 30 months. Medicare is the primary insurer after the 30-month period. You must have Medicare in effect at the termination of the 30 months or your benefits will be drastically reduced when the Suffolk School Employees Health Plan becomes secondary.

The Balanced Budget Act of 1997 extended the coordination period from 18 months to 30 months for any individual whose coordination period began on or after March 1, 1996. So patients who have not completed an 18-month coordination period by July 31, 1997 will have a 30-month coordination period under the new law. **This provision does not apply to individuals who would reach the 18-month point before July 31, 1997.** These individuals would continue to have an 18-month coordination period.

If you are under age 65, the Suffolk School Employees Health Plan provides your primary coverage unless you become disabled. If you develop end-stage renal disease, the Suffolk School Employees Health Plan will provide your primary coverage for the three-month waiting period and 30-month period described above, then Medicare becomes primary.

If you have family coverage, the Suffolk School Employees Health Plan will generally provide primary coverage for your covered dependents until they become eligible for primary Medicare coverage because of age, disability or end-stage renal disease. If your spouse or other dependents are covered under other group health insurance, ask that Plan's carriers or Claims Administrator about primary coverage.

ENROLLING IN MEDICARE:

As An ACTIVE Employee Age 65 or Over: Since the Suffolk School Employees Health Plan automatically provides primary coverage for you and your enrolled dependents, you may delay enrollment in Medicare Parts A and B without penalty until you retire. Or, you may enroll at 65, but delay activating your benefits until you retire and need the coverage.

When you enroll in Medicare, you may elect it as your primary group insurer by notifying your District's Benefits Administrator in writing. **However, if you do choose Medicare as your primary coverage while you are still an Active Employee, Suffolk School Employees Health Plan coverage for you and your enrolled eligible Dependents will end, and your benefits will be drastically reduced.**

When your eligible spouse and other dependents become eligible for Medicare, they also may elect Medicare as the primary group insurer by notifying your District's Benefits Administrator in writing. **However, their benefits would be drastically reduced.**

When You Retire Before Age 65: If you retire before age 65 and are not disabled, you will not be eligible for Medicare until you reach age 65. At 65, you **MUST** enroll. You should contact your local Social Security office three months before you or your spouse turns age 65 to arrange for enrollment in Medicare Parts A and B. Once you have enrolled, your Medicare coverage becomes effective on the first day of the month in which you reach age 65.

When You Retire at Age 65: If you retire at age 65 or older, you **MUST** enroll in Medicare. You should contact your local Social Security office three months before you or your spouse turns age 65 or three months before you retire to arrange for enrollment in Medicare Parts A and B. Once you have enrolled, your coverage becomes effective on the first day of the month following the month in which you retired and are eligible for Medicare.

How to Enroll: You can sign up for Medicare by telephone, mail, or in person. Contact your local Social Security Office.

Note: Not enrolling could reduce your benefits drastically.

If you are not an active employee and you qualify for Medicare coverage under any of the above circumstances, you or your dependents must enroll in Medicare as soon as you or your dependents become eligible for primary Medicare coverage, or there will be a drastic reduction in your health coverage. If you do not enroll in Medicare, the Suffolk School Employees Health Plan will not provide any benefits that Medicare would have provided if you had enrolled in Medicare. This could be very costly. For example, Medicare provides full coverage for the first 60 days of hospitalization, except for a relatively small deductible. If you were eligible for Medicare but not enrolled, during the first 60 days of a hospitalization, the Suffolk School Employees Health Plan would pay only

the Medicare deductible and you would be responsible for the balance of your Hospital bills, which would have been paid by Medicare if you had enrolled.

Suffolk School Employees Health Plan Supplements Medicare: After you retire, the Suffolk School Employees Health Plan will not provide any benefits that could be obtained from Medicare, but it will provide benefits to supplement those available from Medicare.

You will continue to have the same benefits available under the Suffolk School Employees Health Plan as you had before you were eligible to receive **any** Medicare benefits.

The combination of Medicare benefits and those available from the Suffolk School Employees Health Plan will ensure you and your dependents a level of benefits which exceeds that available from either the Suffolk School Employees Health Plan or the Medicare program alone. For this reason, it is very advantageous for you and your dependents to retain coverage under the Suffolk School Employees Health Plan after retirement even though you are also eligible for enrollment in the Medicare program. It is also extremely important that you enroll for both Part A and Part B of the Medicare program as soon as you become eligible for primary Medicare coverage.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Medicare Premium Reimbursement:

Your Employer will NOT reimburse you for Medicare Part A premium costs, if any. If there is a charge for your Medicare Part A coverage because you do not meet the Social Security eligibility requirements, you may keep the Suffolk School Employees Health Plan as your primary coverage and you need not enroll in Medicare Part A. However, you still must enroll in Part B.

Your Employer WILL pay you an amount equal to the usual cost of Medicare Part B coverage when Medicare becomes primary for you or your covered Dependent. If a covered dependent becomes eligible for Medicare coverage, you should notify your former employer. A photocopy of your dependent's Medicare identification card should accompany your letter of notification.

Since reimbursement practices vary from district to district, you should contact your District's Benefits Administrator for information.

Extra charges imposed by Social Security as penalties for late enrollment in Medicare are not reimbursable under the Suffolk School Employees Health Plan.

FILING CLAIMS UNDER MEDICARE AND THE SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN:

Expenses covered by Medicare must be submitted to Medicare before being submitted to the Suffolk Schools Employees Health Plan when Medicare is the primary carrier.

Inpatient Hospital Expenses: When you are admitted to a hospital, you must show both your Suffolk School Employees Health Plan Hospitalization and Medicare cards to the admitting office. You should not be billed for any charges covered under these programs.

The hospitalization portion of the Suffolk School Employees Health Plan will pay the initial Medicare deductible, the Medicare co-insurance 61st-90th day, and the full amount of necessary charges from the 91st to the 365th day.

If you exhaust the 365-day Hospitalization benefits and your Medicare 60-day reserve, the major medical portion of the Suffolk School Employees Health Plan will provide benefits for additional covered inpatient charges.

Outpatient Hospital Expenses: Necessary outpatient hospital expenses incurred for surgery, emergency illnesses, emergency accident cases, diagnostic X-rays and laboratory tests which are not covered by Medicare will be covered by the hospitalization portion of the Suffolk School Employees Health Plan subject to a copayment with certain limitation described in the hospitalization section of this booklet. Outpatient charges should be submitted by the hospital with the Medicare Explanation of Benefits form (EOB) and an itemized bill to:

United Healthcare Insurance Company LLC
PO Box 740800
Atlanta, GA 30374-0800

Network Provider Program and Major Medical Coverage: Whether you receive services from a Suffolk School Employees Health Plan Network Provider or from a provider who does not participate in the Suffolk School Employees Health Plan, you should discuss payment before you receive services. If your provider does not accept Medicare assignment, you may be required to pay the Medicare reimbursable amount at the time of service.

If the provider participates in the Suffolk School Employees Health Plan, you are responsible for paying a copayment to the provider. An example would be the copayment for a Physician's office visit. But the amount you owe may be less, depending on how much Medicare reimburses.

Steps for You to Take: The following four examples describe the steps you should take in various situations when Medicare is your primary coverage. The examples assume that all expenses are covered expenses under both Medicare and the Suffolk School Employees Health Plan.

Example 1: The provider accepts Medicare assignment. The provider participates in the Suffolk School Employees Health Plan.

You will not have to file any claims; the provider will do the paperwork. Medicare and Suffolk School Employees Health Plan benefits are paid directly to the provider. UnitedHealthcare will provide an EOB detailing any patient responsibility.

Example 2: The provider accepts Medicare assignment. The provider does NOT participate in the Suffolk School Employees Health Plan.

Step 1. Medicare benefits are paid directly to the provider. After the Medicare claim is processed and if you are enrolled in Medicare Crossover the claims will be automatically forwarded to United Healthcare for processing from the Medicare Processor. When the Medicare claim is processed you may receive a Medicare Explanation of Benefits (EOB) statement which will tell you that your claim has been forwarded to your "secondary carrier" (The EOB may refer to your "secondary carrier" rather than United Healthcare specifically.) If you receive a Medicare EOB and if this message does not appear, you will have to submit the claim to United Healthcare yourself. If your Medicare carrier does not send you an EOB, you will know that your claim was crossed over if your United Healthcare EOB includes a summary of Medicare's benefits. Medicare Crossover only applies for Medicare Part B and Durable Medical Equipment claims, Medicare Part A and prescription drug expenses are not included.

Step 2. **If you are not enrolled under Medicare Crossover or for Medicare Part A and prescription drug expenses** you must file a Suffolk School Employees Health Plan claim. Send your Medicare EOB statement, the provider's bill, and a signed claim form to United Healthcare.

United Healthcare will send you a reimbursement check for any benefits due under the Suffolk School Employees Health Plan. You should pay the provider directly.

Step 3. If you have not already paid your provider for the portion of the bill that is not Medicare-reimbursable, use the benefits paid to you by the Suffolk School Employees Health Plan to pay your balance. Any remaining portion of the provider's bill is your responsibility.

Example 3: The provider does NOT accept Medicare assignment. The provider participates in the Suffolk School Employees Health Plan.

Step 1. You are responsible for paying any copayment directly to the provider.

Step 2. The provider will file a claim for you with Medicare. When the Medicare claim is processed, you will receive a reimbursement check. After the Medicare claim is processed and if you are enrolled in Medicare Crossover the claims will be automatically forwarded to United Healthcare for processing from the Medicare Processor. When the Medicare claim is processed you may receive a Medicare Explanation of Benefits (EOB) statement which will tell you that your claim has been forwarded to your "secondary carrier" (The EOB may refer to your "secondary carrier" rather than United Healthcare specifically.) If you receive a Medicare EOB and if this message does not appear, you will have to submit the claim to United Healthcare yourself. If your Medicare carrier does not send you an EOB, you will know that your claim was crossed over if your United Healthcare EOB includes a summary of Medicare's benefits. Medicare Crossover only applies for Medicare Part B and Durable Medical Equipment claims, Medicare Part A and prescription drug expenses are not included.

Step 3. Use your reimbursement check from Medicare to pay your provider. Or, if you were required to pay the Medicare-reimbursable amount at the time of service, you will retain this reimbursement.

Step 4 If you are not enrolled under Medicare Crossover or for Medicare Part A and prescription drug expenses you must give your provider the Medicare EOB statement. The provider then submits a claim to United Healthcare for the balance due. Any balance due will be paid to the provider.

Example 4: The provider does NOT accept Medicare assignment. The provider does NOT participate in the Suffolk School Employees Health Plan.

Step 1. You are responsible for paying the provider in full.

Step 2. The provider will file a claim for you with Medicare. When the Medicare claim form is processed, you will receive a reimbursement check. After the Medicare claim is processed and if you are enrolled in Medicare Crossover the claims will be automatically forwarded to United Healthcare for processing from the Medicare Processor. When the Medicare claim is processed you may receive a Medicare Explanation of Benefits (EOB) statement which will tell you that your claim has been forwarded to your "secondary carrier" (The EOB may refer to your "secondary carrier" rather than United Healthcare specifically.) If you receive a Medicare EOB and if this message does not appear, you will have to submit the claim to United Healthcare yourself. If your Medicare carrier does not send you an EOB, you will know that your claim was crossed over if your United Healthcare EOB includes a summary of Medicare's benefits. Medicare Crossover only applies for Medicare Part B and Durable Medical Equipment claims, Medicare Part A and prescription drug expenses are not included.

Step 3. **If you are not enrolled under Medicare Crossover or for Medicare Part A and prescription drug expenses** you must file a claim form with United Healthcare enclosing your receipt from the provider and the Medicare EOB statement. United Healthcare will send you a check for any reimbursement due you under the Suffolk School Employees Health Plan.

CLAIMS DEADLINE:

If you are not enrolled in Medicare Crossover or for all Medicare Part A and prescription drug expenses Suffolk School Employees Health Plan claims must be submitted no later than 90 days after the end of the Calendar Year or 90 days after you receive your Medicare EOB, **whichever is later**.

When You Reside Outside the United States: Medicare does not cover medical expenses incurred outside the United States. The Suffolk School Employees Health Plan pays as primary insurer, whether or not you are enrolled in Medicare. Part B reimbursement from your former employer will be discontinued. You must notify your former employer (in writing) if you will be residing outside the United States.

When you know that you will be residing outside the United States, you must notify your former employer, in writing, and your Social Security office. Social Security will send you a form that you must sign and return, indicating your desire to continue Medicare coverage when you return.

When you return from residing abroad and wish to re-enroll in Medicare, you must contact your Social Security office. You must re-enroll during the next general enrollment period, which is January 1 – March 31. The effective date of your coverage will be July 1. Notify your former employer that you have re-enrolled in Medicare. However, there will be a penalty imposed by Medicare for late enrollment. For each 12-month period you were age 65 or older and were not enrolled in Medicare, your monthly Medicare premium will be 10 percent higher than the usual cost of Part B coverage. You will not be reimbursed for late enrollment penalties.

RE-EMPLOYMENT:

If you return to work with an employer who participates in the Suffolk School Employees Health Plan and meet the eligibility requirements for coverage, the Suffolk School Employees Health Plan will again provide primary coverage for you and your enrolled dependents.

At the time of your re-employment, contact your District's Health Benefits Administrator to arrange to notify United Healthcare and to find out your effective date for Suffolk School Employees Health Plan coverage.

MISCELLANEOUS PROVISIONS

CONFINED ON DATE OF CHANGE OF OPTIONS OR COVERAGE:

If, on the effective date of transfer without break from one health insurance coverage to the other, you are confined to a hospital:

- (1) if the transfer is out of the Plan, and you are confined on the day coverage ends, the Suffolk School Employees Health Plan will be responsible for the inpatient hospital claim only; and
- (2) if the transfer is into the Plan, benefits are payable to the extent they are not paid through the former health insurance program.

TERMINATION OF COVERAGE:

- (1) Coverage will end at the end of the month in which you are no longer eligible to participate in this Plan. Refer to the General Information section.
- (2) If this Plan ends, your coverage will end.
- (3) Coverage for a dependent will end on the date that dependent ceases to be a dependent as defined in the General Information section.

REFUND TO THE PLAN FOR OVERPAYMENT OF BENEFITS

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the covered person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the injury or sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the covered person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

When this provision applies. The covered person may incur medical or dental charges due to Injuries that may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the covered person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the covered person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim that the covered person has against any third party, or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the covered person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to Subrogation or Refund. The covered person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all recoveries and funds paid by a third party to a covered person relative to the injury or sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the covered person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the covered person's third party claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical expenses from the covered person. Also, the Plan's right to Subrogation still applies if the recovery received by the covered person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the covered person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the covered person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a covered person if a covered person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the covered person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or sickness caused by a responsible third party until after the covered person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan (which will be treated as third party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Claims Administrator. The Claims Administrator has a right to request reports on and approve of all settlements.

RESPONSIBILITIES FOR CLAIMS ADMINISTRATION

CLAIMS ADMINISTRATOR. Suffolk School Employees Health Plan is the benefit plan of Suffolk School Employees Health Plan, the Plan Sponsor. United Healthcare is the third party administrator of the Plan and serves as the Claims Administrator at the convenience of the Plan.

The Plan Sponsor and Claims Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Claims Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a plan participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Sponsor will be final and binding on all interested parties.

DUTIES OF THE PLAN SPONSOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a plan participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims and administer the Plan.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the employer and contributions made by the covered employees and retirees.

The level of a participant's contributions will be set by the School District. These participant contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

Benefits are paid directly from the Plan through the Claims Administrator.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Sponsor or Claims Administrator or an agent of either in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Suffolk School Employees Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 11-3085143

PLAN EFFECTIVE DATE: January 1, 2007

PLAN YEAR ENDS: December 31st

PLAN SPONSOR

Suffolk School Employees Health Plan
c/o Eastern Suffolk BOCES
201 Sunrise Highway
Patchogue, New York 11772

CLAIMS ADMINISTRATOR

United Healthcare Insurance Company
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Hartford, CT 06115-0450

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BY THIS AGREEMENT, Suffolk School Employees Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Suffolk School Employees Health Plan on or as of the day and year first below written.

By _____
Suffolk School Employees Health Plan

Date _____

Witness _____

Date _____

Use and Disclosure of Protected Health Information

A. Use and Disclosure of Protected Health Information (PHI)

The Suffolk School Employees Health Plan, through its Third Party Administrator and Pharmacy Benefit Manager (hereinafter collectively referred to as “The Plan”) will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximum and copayments as determined for an individual’s claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amount due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payment;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Care Coordination.
- Reimbursement plan.

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
 - o (a) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements, or
 - o (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity.

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclose PHI to the following for purposes related to administration of these plans:

- Pension plans;
- Disability plans;
- Reciprocal benefit plans;
- Workers’ compensation insurers;
- Employment insurance; and
- Social security administration

C. Adoption of Third Party Administrator and Pharmacy Benefits Manager HIPAA Privacy Policies and Procedures

The Plan adopts the policies and procedures of their Third Party Administrator and Pharmacy Benefits Manager, with respect to all HIPAA privacy requirements for the use and disclosure of PHI and Individual rights with respect to PHI including but not limited to:

- Use and disclosure of PHI received in connection with administration of the Plan
- Confidentiality and security of Participants PHI
- Rights of Individuals with respect to inspection, amending, or access to PHI, right to an accounting of disclosures of PHI and Individuals right to revoke authorization to use or disclose medical information

D. For Purposes of This Section The Board of Trustees of the Suffolk School Employees Health Plan Is the Plan Sponsor

PHI will be disclosed to the Plan Sponsor only upon receipt of an authorization from a Plan member.

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