

**Putnam/Northern
Westchester
Health Benefits
Consortium

Plan Document**

**Form No. PNW-2017-1
(Effective January 1, 2017)
NY State Department of Financial Services Approval Pending**

Important Phone Numbers and Addresses

Aetna – Medical and hospital claims administrator

Customer Service: 1-877-223-1685 POSII Plan
1-800-872-3682 Medicare Advantage Plan

To locate an Aetna participating provider:

<http://www.aetna.com/docfind/index.html>
or call Aetna's Customer Service phone number listed above

Medical and hospital claims should be mailed to:

Aetna, Inc.
P.O. Box 981109
El Paso, TX 79998-1109

CVS Caremark – Prescription drug claims administrator*

Customer Service: 1-866-255-2583

Paper claims should be mailed to:

CVS Caremark Inc.
P.O. Box 52136
Phoenix, Ariz. 85072-2136
Attn: Claims Department

* Excludes prescriptions filled through CanaRx

Putnam/ Northern Westchester Health Benefits Consortium

Office of Risk Management
200 BOCES Drive
Yorktown Heights, NY 10598
914-248-2456

To view a copy of the Plan Document and recent newsletters and to download forms:

<http://www.pnwboces.org/hbc/hbc.htm>

District Benefits Representatives

Enrollment and eligibility questions and updates should be directed to the District Benefits Representative of your employer

New York State Department of Financial Services

<http://www.dfs.ny.gov/>

New York Department of Financial Services One Commerce Plaza Albany, NY 12257 518-474-6600 800-342-3736	New York Department of Financial Services 25 Beaver Street New York, NY 10004-2319 212-480-6400 800-342-3736
---	--

PREFACE

The Putnam/Northern Westchester Health Benefits Consortium Health Plan, a Municipal Cooperative Health Benefit Plan, referred to as the Plan, assures covered individuals during the continuance of the Plan that all benefits hereinafter described shall be paid to them, or on their behalf, in the event they incur covered expenses as defined herein. The Plan is subject to all the terms, provisions and limitations stated on the following pages.

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the Superintendent of Insurance. Municipal Corporations participating in the Municipal Cooperative Health Benefit Plan are subject to Contingent Assessment Liability.

It is intended that the terms of the Plan be legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees, retirees and dependents.

The terms of the Plan of benefits are described herein. The eligibility, coverage and benefit provisions, terms and conditions are subject to change with at least 30-days notice.

Whenever the masculine pronoun is used in this document it shall include the feminine gender unless the context clearly indicates otherwise.

Please refer to your Aetna or CVS Caremark identification card for plan/group numbers.

PLAN DESCRIPTION

PUTNAM/NORTHERN WESTCHESTER HEALTH BENEFITS CONSORTIUM

CONTENTS

Special Notes.....	4
Schedule of Benefits	5
Eligibility	12
How to Use Your Benefits	18
Definitions	20
Continuation of Coverage (COBRA) and Extended Benefits.....	30
Managed Benefits Program	33
Hospital Expense Benefits	38
Medical Expense Benefits	43
Prescription Drug Expense Benefits	49
Rider 2003-1 Contraceptive Drugs or Devices	53
Limitations	54
Miscellaneous Provisions Including Coordination of Benefits & Effects of Medicare	60
General Information Including Appeals Procedure	64
Appendix A: Preventive Services	66
Appendix B: Appeals/ Grievances/ Complaints.....	70
Appendix C: Privacy Policy	80

SPECIAL NOTES

Your employer determines prerequisites for eligibility, which include minimum hours worked per week, waiting periods before coverage becomes effective, and the amount and method for sharing costs between employee and employer. You may contact your own school district's business or personnel office for more information.

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by the Plan. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service. The Plan may delegate this responsibility to a third party.

The Plan assumes no responsibility for the outcome of any covered services or supplies. The Plan makes no express or implied warranties concerning the outcome of any covered services or supplies.

SCHEDULE OF BENEFITS

NOTE

If you are covered under the Consortium's Medicare Advantage Plan or Medicare Part D Prescription Drug Plan, please consult your Evidence of Coverage (EOC) document provided by Aetna or SilverScript for specific information about that plan's benefits and coverage.

All eligible expenses, unless otherwise specified, must be medically necessary, performed or prescribed by a physician, as defined by the Plan, and are limited to usual, reasonable and customary charges and subject to the deductibles, coinsurance/co-payments and maximums shown. See the following chapters for a description of the specific covered expenses and limitations.

This Schedule furnishes benefit elements such as percentages payable and certain limits, etc. The applicable section of this booklet must be reviewed to establish the full extent of benefit payment and limitations.

HOSPITAL EXPENSE BENEFITS

Any overnight admission to a hospital or other facility shall be subject to a **\$250 copayment**.

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a **\$100 copayment per day**. All other hospital/ facility outpatient services shall be subject to a **\$35 copayment per day**. The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.

The hospital benefits coverage is subject to a Benefits Management Program. All of the in-patient hospital and skilled nursing facility benefits provided are subject to the provisions of the Benefits Management Program. In addition, all of the benefits for in-patient admissions to private proprietary hospitals for treatment of mental and nervous conditions (in-patient psychiatric services/treatment) and chemical dependence and approved facilities, other than hospitals, for treatment of chemical dependence are also subject to the provisions of the Benefits Management Program. Pre-admission review for all elective in-patient admissions is required. Emergency, urgent and maternity admissions are excluded from pre-admission review; however, notice of emergency, urgent or maternity admissions is required within 48 hours of admission.

Failure to use the Pre-Admission Review portion of the Benefits Management Program as required shall result in the application of an additional deductible equal to the lesser of 50% of benefits otherwise payable or **\$250 per admission**.

HOSPITAL INPATIENT SERVICES

Hospital Inpatient Services: up to **365 days** per calendar year of confinement for room and board in semi-private accommodations and additional services and supplies (hospital miscellaneous charges) customarily furnished and billed

- **In an In Network General Hospital:** the Plan will pay **100%** of allowable charges, after copayment(s),
- **In an Out of Network General Hospital:** the Plan will pay **90%** of allowable charges, after copayment(s),

Mental Health Conditions: Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital or psychiatric hospital (as defined in the NY mental hygiene law) or non-hospital residential treatment facility appropriately licensed by the NY State Department of Health or equivalent. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. This Plan also covered partial hospitalization services. **In an In Network facility:** the Plan will pay **100%** of allowable charges, after copayment(s).

- **In an Out of Network facility:** the Plan will pay **90%** of allowable charges, after copayment(s).

Chemical/substance/alcohol abuse or dependence: Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital or psychiatric hospital (as defined in the NY mental hygiene law) or non-hospital residential treatment facility appropriately licensed by the NY State Department of Health or equivalent. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. This Plan also covers partial hospitalization, detoxification and rehabilitation services. **In an In Network facility:** the Plan will pay **100%**, of allowable charges, after copayment(s).

- **In an Out of Network facility:** the Plan will pay **90%** of allowable charges, after copayment(s).

Partial Hospitalization: Covered expenses include charges for partial confinement treatment provided in a facility or program for the intermediate short-term or medically directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Inpatient care, partial hospitalization and outpatient treatment must be precertified

In an In Network facility: the Plan will pay **100%**, of allowable charges, after copayment(s).

In an Out of Network facility: the Plan will pay **90%** of allowable charges, after copayment(s).

Hospice care: provided for the length of time that it is required, as determined by the Plan.

- **In an In Network facility:** the Plan will pay **100%**, of allowable charges, after copayment(s).
- **In an Out of Network facility:** the Plan will pay **90%** of allowable charges, after copayment(s).

Skilled Nursing Facility (SNF) limited to an aggregate maximum of **100 days** per spell# of illness.

- **In an In Network facility:** the Plan will pay **100%** of allowable charges, after copayment(s).
- **In an Out of Network facility:** the Plan will pay **90%** of allowable charges, after copayment(s).

A spell of illness shall mean a period that begins on the first day of confinement in an inpatient facility and ends once the individual has been discharged and has not been readmitted for the same illness for ninety consecutive days.

Home Health Care limited to an aggregate maximum of **200 visits** per person, per calendar year.

- **By an In Network provider/agency:** the Plan will pay **100%** of allowable charges, after copayment(s).
- **By an Out of Network provider/agency:** the Plan will pay **90%** of allowable charges, after copayment(s).

Birth Center In Network:

- **In an In Network facility:** the Plan will pay **100%** of allowable charges, after copayment(s).
- **In an Out of Network facility:** the Plan will pay **90%** of allowable charges, after copayment(s).

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, the Plan will use the following allocations of these charges:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if the Plan finds that such action is warranted by reason of a change in factors used in the allocation.

Any overnight admission to a hospital or other facility shall be subject to a **\$250 copayment per stay.**

HOSPITAL OUT-PATIENT/ SURGICAL CENTER SERVICES

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a **\$100 copayment per day. Radiology/Imaging services shall be subject to a **\$50 copayment.** All other hospital/ facility outpatient services shall be subject to a **\$35 copayment per day.** The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.**

Eligible medical services billed by the hospital/ surgical center and limited to the following, after copayment(s):

Emergency Condition	<p>100% of allowable charges, after copayment(s), for care given for an emergency condition at an <u>In-Network</u> facility;</p> <p>100%, of allowable charges, after copayment(s), at an <u>Out-of-Network</u> facility.</p>
Surgery and Radiation Therapy	<p>100%, of allowable charges, after copayment(s), at an <u>In-Network</u> facility;</p> <p>90%, of allowable charges, after copayment(s), at an <u>Out-of-Network</u> facility.</p>
Diagnostic X-Rays and Laboratory Tests	<p>100%, of allowable charges, after copayment(s), at an <u>In-Network</u> facility, when (1) the patient is physically present in the out-patient department; (2) such x-rays and tests are related to and necessary for the diagnosis of an illness or injury; (3) they are ordered by a physician; and (4) they are billed by the hospital;</p> <p>90%, of allowable charges, after copayment(s), for <u>Out-of-Network</u> facilities.</p> <p>No hospital coverage is provided for charges billed by a Physician for interpretation of x-rays and laboratory tests.</p>
Preadmission Testing	<p>100%, of allowable charges, after copayment(s), at an <u>In-Network</u> facility, when (1) the testing is ordered by physician as a planned preliminary to an admission as registered bed patient for surgery in the same hospital; (2) the testing is necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (3) the reservations for a hospital bed and an operating room have been made before the tests are performed; and (4) the patient is physically present at the hospital for the tests;</p> <p>90%, of allowable charges, after copayment(s), for <u>Out-of-Network</u> facilities.</p>
Physical Therapy	<p>100%, of allowable charges, after copayment(s), at an <u>In-Network</u> facility, when (1) the physical therapy treatments are ordered by a Physician; (2) the treatments are in connection with a condition for which the patient had been hospitalized or in connection with surgical care; (3) the treatments begin no later than six (6) months from the date of discharge from the hospital or the date of surgery; (4) the treatments are billed by the hospital; and (5) the treatments are received within one year from the later of (a) date of discharge from the hospital or (b) the date of surgery;</p> <p>90%, of allowable charges, after copayment(s), for <u>Out-of-Network</u> facilities.</p>

Hemodialysis	100% of allowable charges, after copayment(s), at an <u>In-Network</u> facility; 90% of allowable charges, after copayment(s), at <u>Out-of-Network</u> facilities.
Outpatient Chemical Dependence Services/Treatment	100% of allowable charges, after copayment(s), of at an <u>In-Network</u> facility; 90% of allowable charges, after copayment(s), at <u>Out-of-Network</u> facilities.

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a \$100 copayment per day. Radiology/Imaging services shall be subject to a \$50 copayment. All other hospital/ facility outpatient services shall be subject to a \$35 copayment per day. The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

MEDICAL EXPENSE BENEFITS

Annual Deductible (out of network only)

Per Person	\$ 750 per calendar year
Maximum per Family	\$ 2,000 per calendar year

Coinsurance/Copayments/Out-Of-Pocket

For eligible services of Preferred Providers, the member is responsible for a COPAYMENT of

- \$20 per visit for Primary Care providers;**
- \$35 per visit for Specialists;**
- \$25 per visit for Urgent Care Facilities;**
- \$25 for all laboratory services performed per day per provider; and**
- \$25 for all radiology services performed per day per provider.**

The member is not responsible for meeting the deductible or coinsurance.

The co-payment is not credited towards the deductibles.

The co-payment is credited towards the maximum out of pocket amount.

For services of non-Preferred Providers, the member is responsible for ineligible charges plus COINSURANCE equal to 20% of allowable charges after deductibles.

Routine physical exams, well-child visits and immunizations covered under the Plan will not be subject to deductibles, coinsurance or co-payments.

When the combined aggregate of a member's co-payments and coinsurance, referred to as Out of Pocket for the calendar year equals \$3,000 single or \$5,000 family**, further in-network co-payments and coinsurance are waived for the remainder of the calendar year.

****Excludes prescription drug copayments.**

When the combined aggregate of a member's co-payments and coinsurance, referred to as Out of Pocket for the calendar year equals \$4,000 single or \$6,000 family**, further out of network co-payments and coinsurance are waived for the remainder of the calendar year.

****Excludes prescription drug copayments.**

Wellness Services	Refer to Appendix A for details.
Non-Hospital Private Duty Nursing	The Plan will pay 80% of allowable charges up to a maximum payment of \$400 per day.

PRESCRIPTION DRUG EXPENSE BENEFITS

	Retail Pharmacy/ up to 30-days	Mail Pharmacy (or local CVS retail store)/ up to 90-days
Generic	\$5.00	\$5.00
Preferred Brand	\$35.00	\$70.00
Non-Preferred Brand	\$50.00	\$100.00
Specialty	\$100.00	\$200.00

Copayments are waived when a prescription is obtained through PNWMeds/CanaRx

Generic Drug Requirement

Many Brand Name drugs have no Generic equivalent. However, when a Generic is available, if the Brand Name drug is dispensed, then the member will be required to pay the cost difference unless the Generic is not suitable for that patient, as determined by a physician and authorized by CVS Caremark .

This amount will NOT be credited to the member's Out of Pocket Maximum.

Compound Medications

Certain ingredients commonly used in prescription compounds will be excluded from coverage. This means the member will be responsible for some or all costs related to compound prescriptions.

A compound medication is one that is made by combining, mixing or altering ingredients to create a customized medication that is not otherwise commercially available. Compounds can contain substances that have not been rigorously tested for safety or effectiveness. Additionally, not all compounds are approved by the FDA.

Preferred drugs are identified on CVS Caremark's FORMULARY. The FORMULARY is a listing of drugs which identifies the applicable co-payments. You may obtain a copy of the FORMULARY by calling CVS Caremark customer service number on your identification card or access it on their web site.

The Consortium utilizes a network of more than 50,000 preferred pharmacies administered by CVS Caremark. Prescription purchases at pharmacies within the network are subject to the above co-payment. Reimbursements for prescription purchases at non-participating pharmacies are limited to the amount that the Consortium would have been responsible for had a participating pharmacy been used.

The Consortium utilizes CVS Caremark to administer a home delivery prescription drug program for maintenance, or long-term use drugs. Special provisions exist for the use of the Mail Order Pharmacy.

Prescription drug co-payments are limited to an aggregate maximum Out of Pocket maximum of **\$800 per individual or \$1,600 per family per year**.

ELIGIBILITY

WAITING PERIOD

You and your Dependents (see Definitions) are eligible for coverage as specified under "Waiting Period" in the "Definitions" chapter.

OPEN ENROLLMENT PERIOD

Certain provisions of your Open Enrollment Period may be modified by your particular School District. If you have Open Enrollment Period questions, contact your School District's business or personnel office.

Each component employer may allow eligible employees to enter the Plan during an annual open enrollment period. This period shall be from November 1 through November 30 and become effective the following January 1, unless the employer has notified the Consortium that an alternate time period has been selected and has been communicated to its employees.

An individual entering the Plan during the open enrollment period shall not be considered a late enrollee.

EMPLOYEE ELIGIBILITY

Minimum requirements for determination of eligibility shall be established by each individual employer BOCES subject to the following:

An individual who is employed by more than one participating employer shall only be allowed to enroll under one employer.

DEPENDENT ELIGIBILITY

Subject to all conditions of the term "Dependent" as defined in the "Definitions" section, the following section provides additional guidance:

- A. Spouse means an individual to whom the employee is legally married, as recognized in New York State
- B. A natural, adopted or step-child under age 26 is eligible for coverage.
A child under age 26 who is not the natural, adopted or step-child of the employee may be covered if s/he is claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code
- C. Time spent in service with a branch of the United States military, not to exceed 4 years, may be deducted from the age of a child in determining his eligibility for enrollment.
- D. A handicapped child as defined under "Dependent" in the "Definitions" section.
- E. Any person who does not specifically meet one of the criteria outlined in this section shall not be an eligible dependent.
- F. Any person who is on active duty in the armed forces of any country shall not be an eligible dependent

DECLINATION OF HEALTH BENEFITS

Except as noted below, an individual who declines coverage at the time he initially becomes eligible or declines coverage during the annual enrollment period, shall be required to wait until the next Open Enrollment Period Effective Date to become covered under the Plan. This shall include, but not be limited to, an employee who declines coverage in favor of an employee's "buy out" option or to avoid paying the employee's share of the health benefits premium.

Certain changes in your status may enable you to enroll in the Plan at times other than the annual open enrollment period. Where an employee, retiree or dependent rejected initial enrollment in the Plan, he may later enroll if each of the following conditions are met:

The employee, retiree or dependent was covered under another plan at the time coverage was initially offered, and;

Eligibility for coverage under the other plan was lost and coverage was terminated for one of the following reasons:

- continuation coverage required by Federal or State law was exhausted; or
- termination of employment; or
- death of the spouse; or
- legal separation, divorce or annulment; or
- reduction in the number of hours of employment; or
- contract holder (e.g. employer) contributions toward the payment of premium for the other plan were terminated; or
- reaching the maximum eligibility age.

A completed enrollment application must be submitted to the Employer's HR Department within 31-days of termination to be considered timely.

EMPLOYEE COVERAGE

If an employee submits a completed enrollment application to the Employer's HR Department within 31-days of the date of FIRST eligibility, the employee's coverage may become effective on the first day of the month following the month in which the employee applies for coverage.

- A. If an employee requests that coverage begin on the first date of employment, the employer may, at its discretion, comply with the employee's request provided the employee submits a completed enrollment application to the Employer's HR Department on or before the date of employment.
- B. The participating employer may, at its discretion, also require the employee to satisfy a period of employment before coverage for the employee and any eligible dependents becomes effective; however, this employment period must be applied on a uniform basis for all new employees and may not exceed ninety (90) days. The effective date of coverage will be the first day of the month following the month during which the employee satisfies the required period of employment. An employee who is hired on, or otherwise acquires eligibility on, the first day of a month may count that month in establishing his effective date of coverage.

An employee who fails to submit a completed enrollment application to the Employer's HR Department for enrollment during the 31-day period following the date of his first eligibility must then wait for the annual enrollment period to apply for coverage.

DEPENDENT COVERAGE

This section shall not apply to adult children who are enrolling pursuant to the NY State “Age 29” Law.

- A. If an employee applies for Family coverage at the same time as Individual coverage, the effective date of Family coverage will be the same as the employee's.
- B. If an employee submits a completed enrollment application to the Employer's HR Department to add a dependent within 31-days of the date an eligible dependent is first acquired, the effective date of coverage for that dependent will be the first day of the month following the month in which the completed enrollment application is received by the employer's HR Department.. If the completed enrollment application is submitted on the first day of the month and is within 31-days of acquiring the dependent, then coverage may become effective that day.
 - 1. If this change is due to marriage and the employee requests that dependent coverage begin on the date of marriage, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department on or before the date of marriage.
 - 2. If this change is due to the birth or adoption of a child and the employee requests that coverage begin on the date of birth or adoption, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department within 60-days of the date of birth or adoption.
- C. If an employee who has only Individual coverage submits a completed enrollment application to the Employer's HR Department to add a dependent more than 31-days after the acquisition of the eligible dependent (60-days following the birth or adoption of a child), then the employee must wait until the annual enrollment period to add the dependent however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department..
- D. If an employee who has Family coverage submits a completed enrollment application to the Employer's HR Department to add an additional dependent more than 31-days after acquisition of the new dependent (60-days following the birth or adoption of a child), coverage shall become effective no earlier than the first day of the calendar month following the month in which the employee submits a completed enrollment application to the Employer's HR Department; however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department.

CHANGES FROM FAMILY COVERAGE

- A. An enrollee may change from Family coverage to Individual coverage at any time. Adjustment of the employer's and employee's contribution toward the cost of coverage shall not take effect until the first day of the month following the month of the request to change to Individual coverage.
- B. If, and only if, the sole dependent of an enrollee is also an eligible employee or retiree of a participating employer, but not already covered as an employee or retiree, Family coverage may be changed to two Individual coverages. This coverage change shall take effect on the first day of the month following the month of the change request.
- C. If the spouse of an employee enrolled for Family coverage is also an employee or retiree of a participating employer, but not already covered as an employee or retiree, enrollment may be transferred from the currently enrolled spouse to the dependent spouse only during the annual, open enrollment period.

ELIGIBILITY FOR RETIREE BENEFITS

- A. An employee or retiree of a participating employer is eligible to continue coverage in retirement if he:
 - 1. has had at least ten (10) years of full-time service, not necessarily continuous, with the employer from which he is retiring; (In the event that an employer's collective bargaining agreement, internal policy or past practice differs from 10-years, it shall take precedence over this provision of the Plan Document). and
 - 2. has vested for benefits from a retirement system administered by the State of New York; and
 - 3. is at least 55 years of age.
- B. An employee or retiree is also eligible to continue coverage during retirement, regardless of age or length of service with the participating employer, if granted a service connected disability retirement by a retirement or pension plan or system administered and operated by the State of New York due to an injury, illness or disease that resulted from his service with the participating employer.
- C. Employees who have qualified for Social Security Disability payments are considered to be retired for health benefits purposes, regardless of age, provided that they have had at least 10 years of service with the participating employer. Proof of Social Security status will be required.

VESTING FOR BENEFITS

- A. Employees who terminate their employment before age (55) may continue their health benefits if they have;
 - 1. satisfied the minimum requirements established by their retirement system for vesting receipt of their retirement allowance (this need not be done officially); and

2. met the minimum requirements of the employer, other than age, for continuation of health benefits into retirement; and
 3. terminated employment within five (5) years of the date on which they
 - (a) are entitled to receive a retirement allowance or
 - (b) become age fifty five (55).
- B. Eligible employees who wish to continue coverage as enrollees in the program during vested status, must pay both the employer and employee share of the cost of coverage (i.e. the full cost of coverage) from the date their employment terminates until the date they become eligible to receive a retirement allowance from an approved retirement system. After that date, they are only responsible for the retiree's share of payments, if any. All required payments by vestees must be made to the employer where they were formerly employed.
- C. Vestees, who wish to continue coverage into their retirement, must continue health insurance coverage as an enrollee or as a dependent of an enrollee while in vested status. This may include coverage as the spouse of an enrollee of a participating employer different than that of the vestee. Further, if the vestee maintains continuity of coverage as a dependent of an enrollee, he may continue vestee status beyond that date that he initially becomes eligible to receive a retirement allowance from an approved retirement system. **A vestee whose coverage lapses will not be permitted to reinstate coverage, either during vested status or after retirement.**
- D. Once an employee has established eligibility to continue health benefits coverage as a vestee through one participating employer, that eligibility shall not be impaired by subsequent employment and/or enrollment through another participating employer, except when the employee establishes eligibility for coverage as a vestee or retiree through the second, or subsequent employer.

DEATH OF ENROLLEE - SURVIVOR COVERAGE

- A. In the event of the death of an employee or retiree enrolled for Individual coverage, coverage will terminate on the date of death.
- B. In the event of the death of an employee or retiree enrolled for Family coverage, the coverage of any surviving dependents may be continued in accordance with the Federal COBRA continuation coverage rules. The employer shall make a contribution toward the cost of this coverage, for a period of at least 3 months, at the same percentage the employer had been making immediately preceding the death of the employee. After 3 months, the full cost of coverage shall be paid by the surviving spouse or dependents, unless the participating employer establishes administratively or through contract negotiations, a contribution less than 100% for surviving spouses and/or dependents.
1. If the deceased employee or retiree was enrolled for Family coverage and had completed ten (10) years of active service or as an employee having had completed the years of service required to become eligible for vesting in the Teachers' Retirement System or Employees' Retirement System prior to death, then the spouse of the deceased employee may continue coverage as long as the spouse remains unmarried and dependent children may continue coverage for as long as the children would have been eligible had the enrollee lived. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share). A participating employer may choose to reduce the above ten (10) year requirement. In addition, a participating employer may share in the cost of the surviving spouse's and/or dependent's coverage.

2. Regardless of the length of service, if the death of an active employee enrolled for Family coverage results from a work incurred injury, the surviving dependents may be eligible to continue coverage as dependent survivors. To be eligible, the survivors must be entitled to accidental death benefits payable by a retirement system or pension plan administered by the state or civil division thereof, or to death benefits provided under the Worker's Compensation law. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share).
- C. To enroll as a surviving dependent or spouse, the spouse or dependent must inform the business or personnel office of the applicable employer within 90 days of the employee's death. No application made after the 90 day period will be accepted. Since application must be made while coverage is still in effect, the dependent survivor(s) will retain the enrollee's original effective date of coverage.
 - D. The survivor(s) will be issued new identification cards containing the name of the surviving spouse. If there is no spouse and only dependent children are being enrolled, the name of the oldest child will be entered on the card.
 - E. When the dependent survivors are required to pay the full cost of coverage and only one or two survivors are eligible to continue health benefits, one or two Individual enrollments can be established rather than a Family enrollment. If there are three or more survivors and a Family enrollment is established, a change to two Individual enrollments can be subsequently established at any time if only two of these survivors continue to be eligible.

HOW TO USE YOUR BENEFITS

WHEN TO FILE A CLAIM

You should file a claim as soon as you receive charges for services covered by your Plan. Claim forms may be obtained from your employer or claims administrator. In situations where charges may be of a nominal nature (injections, office visits, etc.), it is suggested that you accumulate them until they are sufficient to satisfy the deductible. In situations where the deductible has already been satisfied, accumulating smaller bills will simplify everyone's record keeping by reducing the number of checks issued to you.

All claims must be received by the Plan's claims administrator no later than fifteen (15) months from the date of service. This applies to all claims whether the Consortium is primary payer or not.

HOW TO FILE AN OUT-OF-NETWORK CLAIM FOR MEDICAL SERVICES

- a. patient's name;
- b. description and code of each service rendered;
- c. date of each service rendered;
- d. charge for each service rendered;
- e. diagnosis and code (if more than one diagnosis, an indication of which diagnosis refers to each specific service rendered); and
- f. name, address and tax identification number of the provider of service.

Make a photocopy of the billing you receive from the provider for your records, and send the billing (if paid by you, make sure the bill so indicates) with a completed claim form to the Claims Administrator

AETNA, Inc. P. O. Box 981109 El Paso, TX 79998-1109 1-877-223-1685	CVS Caremark P.O. Box 52136 Phoenix, Ariz. 85072-2136 Attn: Claims Department
---	--

1. A separate claim form must be submitted for each family member for whom a claim is being made. The Plan maintains separate payment and deductible records on you and each of your Dependents. Only one claim form from the major provider of service is needed for each claim submission. If you have made payment to the provider, be sure the bill is marked paid or is accompanied by a paid receipt.
2. Please review the claim form carefully and follow the instructions it contains.

OTHER GROUP COVERAGE

Since this Plan contains a Coordination of Benefits provision, it is important that you advise the Claims Administrator of any other group health plan covering you or your Dependents. You should complete the appropriate section of your claim form in full.

Note: If this Plan is paying as the secondary plan, generally we must be notified of the amount(s) paid by the primary plan before our payment can be made. Please include copies of all providers' bills and statements from other insurance plans. To help you understand what Coordination of Benefits is and how it affects you, refer to the "Coordination of Benefits" Provision.

LATE SUBMISSION OF CLAIM

Initial claims submitted more than 15-months after the date of service will be denied.

INCOMPLETE CLAIM FORMS

When a claim form is submitted without completion of all appropriate items, it is necessary for the Claims Administrator to request the information. This can cause unnecessary delays in providing you with your benefits. If an initial claim is submitted within the 15-month time limit but additional information requested by the Claims Administrator is not received by the later of (a) 15-months from the date of service or (b) 90-days after the request for additional information was made, then the claim will be denied.

ASSIGNMENT OF BENEFITS

Benefits, other than hospital, are usually paid to you, unless the billing submitted includes an "assignment of benefits" signed by you or if the provider is a member of Aetna's Choice POS II. Choice POS II and hospital benefits are usually paid directly to the provider.

Regardless of where the payment is directed, you will always receive written notification of the payment and how it was computed.

LEGAL ACTION

No legal action can be brought to recover under any benefit after 3-years from the deadline for filing claims.

PHYSICAL EXAMINATIONS

The Plan will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

This will be done at no cost to you.

IMPORTANT NOTE

IF THERE IS ANYTHING YOU DO NOT UNDERSTAND ABOUT YOUR PLAN, OR HOW TO USE IT, YOU ARE ENCOURAGED TO CONTACT THE CLAIMS ADMINISTRATOR, YOUR OWN DISTRICTS BENEFITS REPRESENTATIVE OR THE OFFICE OF RISK MANAGEMENT AT BOCES.

DEFINITIONS

This chapter defines some of the more commonly used terms. To help you better understand the benefits and provisions of your Plan, it is important to review these definitions.

ADMINISTRATOR (PLAN)

Joint Governance Board
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

ALLOWABLE CHARGES

The Plan may limit the amount of a provider's charges that will be considered for reimbursement or payment. Charges may be limited to amounts contracted by the Plan or its claims administrator or to amounts that do not exceed Usual, Reasonable or Customary charges. Please refer to the definition of Usual, Reasonable or Customary charges.

AMBULANCE

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

AMBULATORY CARE CENTER

Any public or private establishment with:

- a. an organized medical staff of Physicians;
- b. permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- c. continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- d. which does not provide services or other accommodations for patients to stay overnight.

BIOLOGICALLY BASED MENTAL ILLNESS means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.

BIRTH(ING) CENTER

A facility, duly licensed by the political subdivision of appropriate jurisdiction where located and operating pursuant to that license, which:

- a. is operating primarily as a facility for the delivery of children following a normal, uncomplicated pregnancy;
- b. is operating under the direct, full-time supervision of a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or a Registered Nurse (R.N.);
- c. is equipped to perform routine diagnostic laboratory tests, and to handle medical emergencies;
- d. maintains adequate, written medical records for each patient; and
- e. has a written agreement with at least one local hospital for immediate acceptance of patients who develop complications or require hospital confinement.

CALENDAR YEAR

A period of one year beginning with January 1 and ending December 31.

CHEMICAL DEPENDENCE

Chemical dependence/alcohol abuse; drug addiction/abuse; the use/abuse of any illegal or illegally obtained drug, medication, chemical or other substance; and/or the abuse of any legally obtained drug, medication, chemical or other substance.

CHEMICAL DEPENDENCE TREATMENT FACILITY

A facility in New York State which is certified by the state division of alcoholism and alcohol abuse or by the state division of substance abuse services as a medically supervised ambulatory chemical dependence program; and in other states, a facility accredited by the Joint Commission on Accreditation of Hospital as an alcoholism or chemical dependence treatment program.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- (i) serious suicidal symptoms or other life-threatening self-destructive behaviors;
- (ii) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- (iii) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- (iv) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

COMPANION

This is a person whose presence as a **Companion** or caregiver is necessary to enable a National Medical Excellence Program **(NME) Patient**:

- to receive services in connection with an NME procedure or treatment on an in-patient or
- out-patient basis; or to travel to and from the facility where treatment is given.

CONVALESCENT NURSING HOME/ EXTENDED CARE FACILITY/ SKILLED NURSING FACILITY

Only an institution, other than a hospital, which meets all of the following requirements:

- a. maintains permanent and full-time facilities for bed care of 10 or more resident patients;
- b. has available at all times the services of a Physician;
- c. has a Registered Nurse (R.N.) or Physician on full-time duty in charge of patient care and one or more Registered Nurses (R.N.s), Licensed Vocational Nurses (L.V.N.s) or Licensed Practical Nurses (L.P.N.s) on duty at all times;
- d. maintains a daily medical record for each patient;
- e. is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injuries, and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
- f. is operating lawfully as a nursing home or extended care facility in the jurisdiction where it is located; in no event, however, shall such term include an institution primarily engaged in the care and treatment of chemical dependence.

COINSURANCE/CO-PAYMENT

Coinsurance is the percentage of charges payable by the member.

Co-payment is the dollar amount of charges payable by the member

COVERED EXPENSE/COVERED CHARGE

Usual, reasonable and customary (URC) charges made for **MEDICALLY NECESSARY** services, treatments or supplies rendered in the treatment of illness or injury as of the date of the service, treatment or purchase of the supply giving rise to the charge, except that the expenses incurred for supplies purchased while confined in a hospital for use in part or in whole outside of the hospital will be considered to be incurred after discharge from the hospital.

COVERED PERSON

An individual enrolled and eligible for benefits under this Plan.

CUSTODIAL CARE

This means help in transferring, eating, dressing, bathing, toileting, and other such related activities.

DAYS

Unless otherwise specified, days means calendar days.

DEPENDENT

- a. The covered spouse of an Employee;
- b. The term "children" shall include: natural children, legally adopted children, and step-children under age 26. The term "children" may also include any other children under age 26 if the Employee provides support and maintenance and claims them as dependents in accordance with section 152 of the Internal Revenue Code. Proof of dependency may be required.
- c. A child may be a covered dependent child over age 26 if s/he is unmarried, incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap, chiefly dependent upon the employee for support and maintenance and claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code, and who became so incapable prior to age 26. Proof of such incapacity and dependency must be furnished to the Plan at least 31 days prior to the child's 26th birthday. If a dependent child is 26 or older at the time of initial enrollment, and that child was incapable of self-sustaining enrollment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap before age 26, such proof as required by the Plan must be submitted within 31 days of the initial effective date of coverage. The Administrator may require, at reasonable intervals, subsequent proof of the child's disability and dependency.

Excluded as a Dependent under a., b. and c. above is:

1. a spouse divorced from the Employee;
2. a Domestic Partner;
3. any person(s) while on active duty in any military service of any country.

Refer to "Eligibility", and "Continuation of Coverage (COBRA) and Extended Benefits" sections for additional information.

DISABILITY/PERIOD OF DISABILITY

Any period of illness or injury, or multiple illnesses or injuries arising from the same cause, including any and all complications therefrom, which are not separated by complete recovery as certified by the attending Physician and return to active full-time employment in the case of the Employee; or in the case of a Dependent, return to the resumption of the normal activities of a person of the same age and sex in good health. For the purpose of renewing in-patient hospital and/or convalescent nursing home/extended care facility/skilled nursing facility benefits, a new period of disability shall begin when the Covered Person has not been confined in such a facility for at least 90 days.

DURABLE MEDICAL EQUIPMENT

Appliances and/or supplies which are: medically necessary; recommended by a Physician for therapeutic use; considered to be appropriate by standards of professional medical practice to treat an illness or injury; and are approved by the Plan.

EMERGENCY ADMISSION

One where the physician admits the person to the **hospital or treatment facility** for an "emergency condition" as defined later in this section.

EMERGENCY CARE

This means the treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMERGENCY CONDITION

This means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

EMPLOYER/PARTICIPATING EMPLOYER

The Employer is, individually or collectively, the various school districts and BOCES which elect to become Participating Employers in the Putnam/Northern Westchester Health Benefits Consortium.

FORMULARY

A formulary is a listing of prescription medications identifying applicable co-payments for preferred and non-preferred drugs. Preferred drugs are selected based upon approval of the Federal Food and Drug Administration (FDA) and cost effectiveness. Non-preferred drugs must also be approved by the FDA but are more costly. The co-payment is highest for non-preferred drugs.

GENDER PRONOUNS

Whenever the masculine pronoun is used in this document it shall include the feminine gender unless the context clearly indicates otherwise.

GENERIC DRUG

A drug, available only upon the written prescription of a Physician, used for the treatment of an illness or injury and supplied in the form of its generic or chemical name rather than in the form of a proprietary, trade or brand name product.

HOME HEALTH AIDE

A person, other than a Physician or a nurse, who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY

A Hospital or a home health care agency which primarily provides skilled nursing service or other therapeutic service under the supervision of a Physician or Registered Nurse, is run according to rules established by a Physician, maintains clinical records on all patients and does not primarily provide custodial care or care and treatment of the mentally ill. In those jurisdictions where licensure or certification by statute exists, the Home Health Care Agency must be licensed or certified and operated according to the laws that pertain to agencies which provide home health care.

HOME HEALTH CARE PLAN

A plan for medical care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Convalescent Nursing Home/Extended Care Facility/Skilled Nursing Facility if he did not have the care and treatment stated in the plan, and is approved by the Plan's Managed Benefits Program Coordinator.

HOSPICE

An organization, licensed by the state of residence, which provides a coordinated set of services rendered at home or in out-patient or institutional settings for individuals suffering from a disease or condition with a terminal (within six months) prognosis.

HOSPICE CARE/PROGRAM

A program of care which offers 24-hour services to terminally ill patients in the home, on an outpatient basis and/or on a short-term in-patient basis, and included such services and items as nursing care, physical therapy, medical social services, home health aide, medical supplies, Physician services, short-term in-patient care and counseling for the patient and his family.

HOSPITAL

This means a short-term, acute, general hospital, which:

- (1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- (2) Has organized departments of medicine and major surgery;
- (3) Has a requirement that every patient must be under the care of a physician or dentist;
- (4) Provides 24-hour nursing service by or under the supervision of a registered professional nurse (RN);
- (5) If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Laws 89-97(42 USCA 1395x(k));

- (6) Is duly licensed by the agency responsible for licensing such hospitals; and
- (7) Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitation care.

**HOSPITAL (OR CONVALESCENT NURSING HOME/
EXTENDED CARE FACILITY/SKILLED NURSING FACILITY)
MISCELLANEOUS CHARGES**

The usual, reasonable and customary amounts charged by the hospital or convalescent nursing home/extended care facility/skilled nursing facility for necessary services, medicines, supplies or services for diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the hospital or convalescent nursing home/extended care facility/skilled nursing facility) while the Covered Person is hospital confined and a charge is made for room and board.

ILLNESS/ACTIVE ILLNESS

Any sickness or disease which manifests treatable symptoms and which requires treatment by a Physician.

INCURRED DATE

The date a charge for a covered expense shall be deemed to be incurred. The Incurred Date shall be the latest of the following to occur the date a purchase is contracted; the date delivery is made; or the actual date a service is rendered.

INJURY

Any accidental bodily injury sustained while the individual is covered under the Plan and which requires treatment by a Physician.

IN-PATIENT/IN-PATIENT CARE

The period of time during which a Covered Person is treated at a hospital or a convalescent nursing home/extended care facility/skilled nursing facility as a registered bed patient. Inpatient care includes charges for room and board and (hospital or convalescent nursing home/extended care facility/skilled nursing facility) miscellaneous charges.

INTENSIVE/CORONARY/ACUTE CARE CHARGE

A service prescribed by the attending Physician, as a medical necessity, which is normally reserved for critically and seriously ill patients requiring constant audio-visual surveillance, which provides room and board, care by registered graduate nurses or other highly trained hospital personnel, and special equipment and supplies immediately available on a standby basis, and is rendered at a location segregated from the rest of the hospital's facilities. This term does not include care in a surgical recovery or post-operative room.

MANAGED BENEFITS PROGRAM

A managed benefits program which requires a pre-admission review of proposed hospitalization, or notice of an emergency admission, in order to establish and inform the Covered Person of the number of days of hospitalization for which the Plan will provide benefits.

MANAGED BENEFITS PROGRAM COORDINATOR

AETNA, Inc.
1-877-223-1685

MEDICALLY NECESSARY/ MEDICALLY NECESSARY CARE

Care which is:

- a. consistent with the symptoms or diagnosis and treatment of a condition, disease, ailment or injury; and
- b. in accordance with generally accepted medical practices; and
- c. not solely for convenience of the Covered Person, Physician or other service provider, and
- d. the most appropriate supply or level of service which can be safely provided.

When it is questionable that an expense incurred is for medically necessary care, the Managed Benefits Program Coordinator shall have the appropriate medical authority to establish the medical necessity of such expense. Just because a physician orders or suggests a service does not make such expense medically necessary.

MEDICARE

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by the Social Security Amendment of 1965 or as later amended.

OUT-PATIENT/OUT-PATIENT CARE

A Covered Person shall be considered to be an "Out Patient" if treated in a hospital on a basis other than as a registered bed patient. Out-patient care includes 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. Out-patient care shall also include covered services rendered in the Physician's office, laboratory or X-ray facility, ambulatory care center or free-standing surgical facility, or the patient's home.

PHYSICIAN

To the extent performing services covered by the Plan, a person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.) and Doctor of Optometry (O.D.). The term Physician shall also be extended to include a Doctor of Psychology (Ph.D.), Registered Physical Therapist (R.P.T.), Licensed Speech Language Pathologist and Audiologist, Registered Nurse Practitioner (R.N. Practitioner) and Registered Occupational Therapist (O.R.T.). The term Physician shall also include a social worker who is certified pursuant to article one hundred fifty-four of the New York State Education Law; and who, in addition, has either six or more years of post-degree experience in psychotherapy, satisfactory to the (New York) state board for social work, or six or more years of post-degree experience in psychotherapy under the supervision, satisfactory to the (New York) state board for social work, of a psychiatrist, a certified and registered psychologist or another social worker who is qualified as a social worker as defined above, or has a combination of the (New York) state required experience specified above which totals an aggregate of six or more years, satisfactory to the (New York) state board for social work; and who in addition is listed by the (New York) state board for social work as qualified for reimbursement. A qualified social worker shall also include a certified social

worker providing services outside the State of New York, provided such social worker is, by the resident state statutes, qualified to provide such services, and required by the resident state statutes to be covered under a group health plan or service.

PLAN NAME

The name of the Plan is the

PUTNAM/NORTHERN WESTCHESTER HEALTH BENEFITS CONSORTIUM HEALTH PLAN.

The Plan currently utilizes AETNA for medical/hospital claims administration and CVS Caremark as prescription drug claims administrator.

Aetna's Medicare Advantage PPO and CVS Caremark's Medicare Part D drug program are provided for most Medicare eligible members.

PREFERRED PHYSICIAN/PROVIDER

A Physician or hospital who/which has a contractual agreement with the Plan or any of its administrators to provide medical services to Covered Persons at pre-agreed upon rates.

PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

The prompt evaluation and treatment of an emergency medical condition, and/or non-airborne transportation of the patient to a hospital; provided however, where the patient utilizes non-airborne emergency transportation pursuant to this subsection, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

PSYCHIATRIC SERVICES/TREATMENT

Treatment of mental and nervous disorders, including services provided by a Doctor of Medicine, and services provided by a Doctor of Psychology. Psychiatric Services/Treatment shall not include services and treatment related to chemical dependence.

REHABILITATION FACILITY

A legally operating institution or distinct part of an institution which:

- a. has a transfer agreement with one or more hospitals;
- b. is primarily engaged in providing comprehensive, multi-disciplinary physical restorative services, post-acute hospital and rehabilitative in-patient care; and
- c. is duly licensed by the appropriate government agency to provide such services.

A rehabilitation facility shall not include an institution which provides only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis, unless such facility is licensed, certified or approved as a rehabilitation

facility for the treatment of medical conditions or chemical dependence in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for Accreditation of Rehabilitation Facilities.

For determination of benefits under the Plan, a rehabilitation facility shall be considered on the same basis as a convalescent nursing home/extended care facility/skilled nursing facility.

ROOM AND BOARD CHARGES

These are charges made by an institution for room and board and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

SEMI-PRIVATE CHARGE

The charge made by a hospital for a room containing two or more beds but does not include the charge made by the Hospital for Intensive Care/Coronary Care/Acute Care.

USUAL, REASONABLE AND CUSTOMARY CHARGES (URC)

The normal and necessary charges made for similar services by the providers of medical services who are practicing in the same geographic area or the actual charge, whichever is less. Determination of whether or not a charge is URC shall be made by the Claims Administrator based on nationally obtained and recognized survey data or on data received from an insurance company which, as a major portion of its business, is involved in the adjudication of health care claims. URC shall also mean, and is interchangeable with, Reasonable charge, Customary charge, Usual Customary and Reasonable (UCR) charges, and references of a similar nature used to describe Covered Expenses, charges or allowable amounts.

WAITING PERIOD

That period of time between the Employee's date of eligibility and/or hire and the date the Employee becomes covered under this Plan.

The Waiting Period for Employees of each respective Participating Employer shall be determined by the Participating Employer.

CONTINUATION OF COVERAGE

* VERY IMPORTANT NOTICE *

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA) and New York State Insurance Laws require most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates, in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of those laws. **(Both you and your spouse should take the time to read this notice carefully.)**

I. COBRA

If you are a covered Employee or covered retiree, of one of the School Districts (called the "Employer") participating in the Putnam/Northern Westchester Health Benefits Consortium Health Plan (called the "Plan"), you have a right to choose this continuation coverage for up to 36-months if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

If you are the spouse of an Employee (or retiree) covered by the Plan, you have the right to choose continuation coverage, for up to 36-months, for yourself if you lose group health coverage under the Plan for any of the following reasons:

1. the death of your spouse;
2. a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. your divorce or legal separation from your spouse.

In the case of a dependent child of an Employee covered by the Plan, he or she has the right to continuation coverage, for up to 36-months, if group health coverage under the Plan is lost for any of the following reasons:

1. the death of a parent;
2. the termination of a parent's employment (for reasons other than gross misconduct) or reduction in parent's hours of employment with the Employer;
3. the parents divorce or legal separation; or
4. the dependent ceases to be a "dependent child" under the Plan.

Note: A Young Adult who loses eligibility coverage under the NY "Age 29" law will not become eligible for COBRA Continuation Coverage.

Under the law, the Employee (or covered retiree) or a family member has the responsibility to inform the Employer's benefit office of a divorce, legal separation, of the Social Security determination that a qualified beneficiary was disabled at the time of the Employee's termination or reduction in hours, or a child losing dependent status under the Plan within 60-days of the qualifying event. The Employer has the responsibility to

notify the Plan Administrator of the Employee's death, termination of employment or reduction in hours, or Medicare entitlement.

The Employer will in turn notify you that you have the right to choose continuation coverage. You have 60-days from the date you would lose coverage because of one of the events described above to inform the Employer that you want continuation coverage.

If you do not choose continuation coverage, your group health coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years.

However, the law also provides that your continuation coverage may be cut short for any of the following reasons:

1. the Employer no longer provides group health coverage to any of its Employees;
2. the premium for your contribution coverage is not paid within the required period; or
3. the individual becomes covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such individual; or
4. the individual becomes entitled (that is, covered) under Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage; you will have a grace period of 45-days (after the date you initially elect COBRA coverage) to pay the first premium.

II. New York State "Age 29" Law

Coverage for Young Adults Through Age 29

An unmarried child of an employee/retiree/surviving spouse who loses eligibility under the Plan, may extend coverage through age 29 if s/he is not insured or eligible for coverage under any employee health benefit plan or Medicare as an employee or member.

An individual who wishes to elect continuation coverage under this law must:

- o inform the employer's benefits office, in writing, within 60-days following the date coverage would otherwise terminate due to age; or
- o or
- o Within 60-days after newly meeting the requirements for Young Adult coverage when coverage for the Young Adult previously terminated; or
- o During an annual 30-day open enrollment period (November 1-30 with following January 1 effective date).

III. Extended Benefits

In addition to the Continuation Coverage available pursuant to COBRA, benefits shall be extended during a period of total disability for hospital confinements commencing or surgery performed within the next 31-days for the injury, sickness or pregnancy causing the total disability.

If the termination of coverage is due to termination of active employment an extended benefit shall be provided during total disability, with respect to the sickness, injury or pregnancy which caused the disability, of at least 12 months subsequent to coverage termination unless coverage is afforded for the total disability under another group plan.

You may also be eligible for coverage through your state's health insurance exchange or marketplace. In New York, you can review exchange options by going to the following website:

<https://nystateofhealth.ny.gov/>

IV. Supplementary Conversion and Continuation Rights for Military members

Employees or members covered under this Plan who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled to have supplementary conversion and continuation rights in certain circumstances; the employer has not agreed to continue coverage while the employee or member is on active duty; and coverage is requested within 60-days of being ordered to active duty. Please contact the Plan Administrator for more information if this may apply to you or a family member.

If you have any questions about the (COBRA) law, or New York extensions, please contact your District Benefits Representative in the Business or Personnel Office. Also, if you have changed marital status, or you or your spouse have changed address, please notify your Benefits Representative.

MANAGED BENEFITS PROGRAM

This Program has been designed to encourage the efficient and effective use of hospital and medical services by providing you with medical and financial information before the services are provided. The benefits provided by your Plan are limited to charges for services which are medically necessary and appropriate for the care and treatment of an illness or injury. As such, charges are covered only if they are necessary for the care and treatment of a covered illness or injury. This includes the type of service and length of confinement, if applicable.

Please refer to Appendix B for additional information about Utilization Review and your right to appeal negative decisions made regarding the medical necessity or experimental/ investigative aspect of services, treatment or supplies.

ADMISSION AND REVIEW PROGRAM

- **Elective Admission to a Hospital or Skilled Nursing Facility:** At least five working days prior to a scheduled non-emergency, elective in-patient hospitalization or admission to a Skilled Nursing Facility. Most psychiatric and chemical dependence admissions are planned and therefore require authorization at least five days prior to the admission.
- **Emergency Hospital Admission:** Within 48 hours of an emergency or maternity hospitalization.
- **Home Health Care Services, Private Duty Nursing or Hospice Care:** At least five working days prior to commencement of Home Health Care services, Private Duty Nursing or Hospice care.
- **Elective admission to a facility specializing in psychiatric, mental/nervous conditions or substance abuse, as an inpatient or patient in an intensive outpatient day therapy program:**
At least five working days prior to a scheduled admission.

AETNA must be notified in a timely manner about the above services for you to receive the full benefits your health care plan offers. It is the patient's responsibility to notify Aetna about the planned treatment if the provider does not participate in Aetna's Choice POS II.

Aetna, Inc.
1-877-223-1685

Failure to use the Program as specified above will result in the application of a separate deductible (equal to 50% of benefit otherwise payable up to a maximum of \$250), per admission, being applied to any service for which pre-certification is required. Additionally, the member failing to use the Program may assume the risk of liability for services later deemed to be medically unnecessary or available from another primary plan.

CONCURRENT REVIEW PROGRAM

The Concurrent Review Program is initiated when the Admission and Review Program is used. The Program will monitor the hospital or skilled nursing facility stay or Home Health Care or Private Duty Nursing services to determine the continued medical necessity of the treatment plan. If confined for days for which the Concurrent Review Program determines that no medical necessity exists, the Plan may consider the expenses incurred during such days not to be covered expenses.

What happens when you call?

As soon as you are aware of a recommended hospitalization or out-patient treatment, you should call AETNA. When you call, please have the following information available:

- Your name, address and Social Security number.
- Patient's name, address, Social Security number and age.
- Physician's name, address and phone number.
- Admitting hospital name and phone number, if appropriate.
- Employees name and Claim Administrator's name.
- Medical condition and planned procedure, if known.

Upon contact, AETNA will provide you with a unique case number to identify and verify your compliance with the Managed Benefits Program requirements.

AETNA will contact the hospital and physician to obtain necessary medical information to evaluate the admission and the treatment plan. AETNA may require that you obtain a second opinion before having an in-patient or out-patient surgical procedure. Regardless of the second opinion recommendation, the decision concerning the surgery is yours.

You will receive information about the proposed treatment including alternative treatments. When unnecessary or inappropriate care is identified, the AETNA Medical Director will discuss the case with your attending physician. Upon completion of the review process, AETNA will advise you, in writing, of its recommendations.

If the admitting doctor determines that you or a covered individual needs to be confined for a longer period than for which benefits were initially authorized by AETNA, the doctor must request authorization from AETNA by phone for the additional period of confinement.

If you or your physician disagree with the recommendation, an appeal process gives you the opportunity to have your case reconsidered. When a request for reconsideration is made, AETNA reviews all available information. The final recommendation is sent to you, the Claims Administrator and the physician. The Plan Administrator makes the final decision regarding reimbursement.

Please Remember....

It is the employee's responsibility to call the Managed Benefits Program Coordinator when required. Asking the hospital, doctor or anyone to call does not relieve the employee of his responsibility - if the other party does not call.

PHYSICAL EXAMINATIONS

The Plan will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

LARGE CASE MANAGEMENT PROGRAM

This Program provides special benefit provisions whenever the Plan's Claims Administrator and your Managed Benefits Program Coordinator identify certain large claim situations. Examples of illness, injury or large catastrophic claims (called "large claim identifiers") which will be referred to the Managed Benefits Program Coordinator include:

- Premature and Multiple Births
- Neonatal Illnesses
- Chronic Neurological Diseases (Multiple Sclerosis, ALS-Lou Gehrig's Disease, Muscular Dystrophy)
- Major Trauma and Multiple Fractures
- Brain Injury
- Spinal Cord Injury
- Amputation
- Leukemia
- Immune Deficiency Syndromes (AIDS, Lupus, and Crohn's Disease)
- Severe Burns
- Stroke (CVA)
- Chronic Obstructive Pulmonary Disease (COPD)
- Any claim expected to exceed \$25,000 in claim costs
- Any claim expected to exceed 30 days of in-patient care

When a large claim identifier occurs, the Managed Benefits Program Coordinator will be contacted to determine if a long-term plan of care needs to be developed in consultation with the patient's attending Physician(s).

Notice of a large claim identifier occurrence can be provided to the Managed Benefits Program Coordinator by the patient, the Employee, the Employer or the Claims Administrator. Immediate notification of a large claim identifier is essential to an effective long-term plan of care.

NATIONAL MEDICAL EXCELLENCE PROGRAM (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

TRAVEL EXPENSES

These are expenses incurred by an NME Patient for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a Companion for transportation when traveling to and from an NME Patient's home and the Medical Facility to receive such services.

LODGING EXPENSES

These are expenses incurred by an NME Patient for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a Companion for lodging away from home:

- while traveling with an NME Patient between the NME Patient's home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the Companion's presence is required to enable an NME Patient to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a hospital or other temporary residence from which an NME Patient travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

TRAVEL AND LODGING BENEFIT MAXIMUM

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
 - one year after the day the procedure is performed; and
 - the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

LIMITATIONS

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one Companion per night.

HOSPITAL EXPENSE BENEFITS

If you are covered under the Consortium's Medicare Advantage Plan, please consult your Evidence of Coverage (EOC) document provided by Aetna for specific information about that plan's benefits and coverage.

If an individual, while covered under the Plan, has incurred covered Hospital Expenses for treatment of an illness or injury, the Plan shall pay the amount(s) and/or percentage(s) indicated in the Schedule of Benefits section. Hospital Expense Benefits are subject to all limitations and conditions of the Plan, including Usual, Reasonable and Customary Charges.

IN-PATIENT HOSPITAL CHARGES

If a Covered Person incurs necessary expenses which are recommended and approved by a Physician for hospital care for diagnosis or treatment of an illness or injury, the Plan shall pay hospital charges not exceeding the maximum amount specified in the Schedule of Benefits for such charges.

- a. *Room and Board - General Nursing Care:* The Plan shall pay the Semi-Private or Intensive/Coronary/Acute Care Charge for a Covered Person who is confined on an inpatient basis for the treatment of an illness or injury not to exceed the amounts indicated in the Schedule of Benefits. (The allowance for a private room shall be an amount equal to the hospital's most common semi-private room rate.)
- b. *Hospital Miscellaneous Charges:* The Plan shall pay the usual, reasonable and customary amounts charged by the hospital for necessary services, medicines, blood (if not replaced) and plasma, and supplies for diagnosis and treatment of the illness or injury for which the Covered Person is confined (except services of a Physician, Dentist, special nursing in any form, or drugs or supplies not consumed or used in the hospital). Hospital Miscellaneous Charges shall be payable for all days of hospitalization for which the hospital's room and board charges are payable.
- c. *Charges by a birthing center* shall be considered eligible charges to the extent such charges would have been covered if provided by a hospital as part of an in-patient confinement.
- d. Coverage is provided for such period as is determined by the attending physician in consultation with the patient to be medically appropriate after such person has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy.

SKILLED NURSING FACILITY

Conditions for Skilled Nursing Facility Care: The Plan will pay for care in a Skilled Nursing Facility described below when the following conditions are met:

- a. Care in a skilled nursing facility must be medically necessary. Care is medically necessary when it must be furnished by skilled personnel to assure the safety of the patient and achieve the medically desired result. Custodial care is not covered. In order to determine whether care is medically

necessary, the guidelines used by the Federal government's Medicare program will be applied. The Managed Benefits Program Coordinator, in conference with the patient's Physician, will verify medical necessity and establish when skilled nursing facility care is appropriate and eligible for benefits.

- b. Coverage will only be provided for as long as in-patient hospital care would have been required if care in a skilled nursing facility were not provided.

Kind of Skilled Nursing Facility. The facility must be either:

- a. accredited as a skilled nursing facility by the Joint Commission on Accreditation of Hospitals; or
- b. certified as a participating skilled nursing facility under Medicare.

Covered Services. The Plan will pay the charges of a skilled nursing facility for:

- a. a semi-private room (if a private room is occupied, the Plan will pay an amount equal to the facility's most common charge for a semi-private room);
- b. physical, occupational and speech therapy;
- c. medical social services;
- d. drugs, biologicals, supplies, appliances and equipment furnished for use in the facility and which are ordinarily provided by the facility to patients; and
- e. other services necessary for the patient's health which are generally provided by the facility.

OUT-PATIENT HOSPITAL/SURGICAL CENTER CHARGES

Hospital charges for out-patient services are covered in full, subject to URC and deductible, when: the patient is physically present; they are for the diagnosis or treatment of illness or injury; they are ordered by a Physician; and they are billed by the hospital.

- a. *Emergency condition:* Benefits are payable for outpatient or emergency room charges (Physician's charges are covered under the Medical Expense Benefits portion of the Plan) for care given by a professional provider in or outside of a hospital for an emergency condition.
- b. *Surgery and Radiation Therapy:* Benefits are payable for out-patient hospital charges (excluding Physician charges) related to the performance of a surgical operation or radiation therapy.
- c. *Diagnostic X-Rays and Laboratory Charges:* Benefits are payable for out-patient hospital charges (excluding Physician charges) for diagnostic X-ray examinations and laboratory tests, including such examinations and tests performed as part of pre-admission testing for a proposed, covered hospitalization.
- d. *Pre-Admission Testing:* Hospital services for pre-admission testing in the out-patient department of a hospital are covered, when:
 - the testing is ordered by a Physician as a planned preliminary to the patient's admission as a registered bed patient for surgery in the same hospital;
 - the testing is necessary for, and consistent with, the diagnosis and treatment of the condition for which the surgery is to be performed;

- the reservations for a hospital bed and an operating room have been made before the tests are performed; and
 - the patient is physically present at the hospital for the tests.
- e. *Physical Therapy:* Benefits are payable for physical therapy performed in the out-patient department of a hospital and billed by the hospital, provided: such therapy is in connection with a condition which necessitated hospitalization or surgery; treatment begins within six months from the date of the hospital discharge or surgery; and treatment is received within one year of the hospital discharge or surgery.
- f. *Hemodialysis Treatment:* Benefits are payable for hemodialysis treatment performed in the out-patient department of a hospital and billed by the hospital.

EMERGENCY HOSPITAL AMBULANCE SERVICE

The Plan will pay for emergency ambulance service under the following conditions: the ambulance service must be owned and operated by the hospital and it is billed for by the hospital; there is an emergency and you need an ambulance; and you are taken to the nearest hospital which provides the necessary emergency out-patient care you need or if you are admitted to that hospital as a registered bed patient.

HOME HEALTH CARE

Benefits are payable for Home Health Care treatment stated in a Home Health Care Plan, performed while the individual is under the care of the Physician approving the Home Health Care Plan.

Type of Home Health Care Agency: The Plan will pay for home care visits provided by a home care agency certified or licensed under Article 36 of the New York State Public Health Law. If the home care is provided outside of New York State, the provider of care must have an appropriate operating certificate or license issued by the appropriate state agency where the care is rendered. The provider outside of New York State must be a hospital or non-profit or public home health service or agency.

Conditions for Home Health Care: The Plan will pay for home care visits only if the following conditions are met:

- a. If the patient did not receive home health care visits, the patient would have to be hospitalized in a hospital or cared for in a skilled nursing facility. In other words, the home health care visits are a substitution for hospital care or care in a skilled nursing facility.
- b. A Plan for the patient's home health care is established in writing, ordered or approved by the patient's Physician.

Home Health Care Services Covered: Payment will be made for the following home care services:

- a. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.).
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- c. Physical, occupational and speech therapy if the home care agency or hospital provides those services.
- d. Medical supplies, drugs and medications prescribed by a Physician, but only if the Plan would have paid for those items if the patient was in a hospital or confined in a skilled nursing facility.

- e. Laboratory services provided by or on behalf of the home care agency or hospital.

Number of Home Care Visits: Each visit by a member of a home care team is counted as one home care visit. Four hours of home health aide services are counted as one home care visit. Each Covered Person is limited to 200 home health care visits per calendar year.

HOSPICE CARE

Hospice Organizations: The Plan will pay for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those issued in New York by a state agency in the state where the hospice care is provided.

Hospice Care Covered: Hospice care is covered during the period when the hospice has accepted the patient for its hospice program. The following services provided by the hospice organization are covered:

Bed-patient care either in a designated hospice unit or in a regular hospital bed.

Home care and out-patient services which are provided by the hospice and for which the hospice charges the patient. The services may include at least the following:

- Intermittent nursing care by an R.N., L.P.N. or home health aides.
- Physical, speech, occupational and respiratory therapy.
- Social services.
- Nutritional services.
- Laboratory tests and X-ray examinations.
- Chemotherapy and radiation therapy, when required for control of symptoms.
- Medical supplies.
- Drugs and medications prescribed by a Physician and which are considered approved under the appropriate Governmental authorities. The Plan will not pay when the drug or medication is of an experimental nature.
- Bereavement services provided to your family during your illness and until one year after death.

CHEMICAL DEPENDENCE TREATMENT BENEFIT

Benefits are payable, up to the number of days specified in the Schedule of Benefits, for chemical dependence treatment provided by a Hospital, or a Chemical Dependence Treatment Facility, on an in-patient basis.

MEDICAL CONDITIONS RESULTING IN INFERTILITY

- a. Coverage shall not be excluded for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.
- b. Benefits are payable for charges for hospital care, surgical or medical procedures or prescription drugs which would correct malformation, disease or dysfunction resulting in infertility, diagnostic tests and procedures, including prescription drugs necessary to determine infertility or that are necessary in connection with hospital care or surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Coverage shall not include diagnosis or treatment in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental.
- c. Paragraph b is limited to individuals whose ages range from twenty-one (21) through forty-four (44), and whose diagnosis and treatment has been prescribed as part of a physician's overall plan of care.

MEDICAL EXPENSE BENEFITS

If you are covered under the Consortium's Medicare Advantage Plan, please consult your Evidence of Coverage (EOC) document provided by Aetna for specific information about that plan's benefits and coverage.

All charges allowable under your Medical Expense Benefits are based on usual, reasonable and customary charges as defined in the "Definitions" section. Only charges for medically necessary treatment or diagnosis of an illness or injury are considered allowable.

Note: Payment for certain types of services is limited. Please refer to the Schedule of Benefits, Limitations and other applicable provisions of the Plan.

THE DEDUCTIBLE

Before the Plan will pay for out of network services, the Deductible amount shown in the Schedule of Benefits must be met. The Deductible must be satisfied only one time each calendar year regardless of the illness or injury, type of services or treatment provided.

If three or more family members incur covered expenses in any calendar year which causes the total family deductible amounts to reach the Deductible "Per Family" shown in the Schedule of Benefits, the Deductible will be considered to be met for all family members for all other covered expenses incurred in that calendar year.

COINSURANCE/CO-PAYMENT

After the deductible is satisfied, the Member is generally responsible for 20% coinsurance for out of network services.

Services of Preferred Providers are generally subject to the co-payment but not the deductible or coinsurance.

MEDICAL EXPENSE BENEFITS

1. a.
 - 1 Medical or surgical services by a "Physician," including second surgical opinions and outpatient treatment of mental health conditions and chemical dependence.
2. The following medical services and supplies that are recommended by a Physician, and are medically necessary:
 - a. anesthesia, including the charge for its administration;
 - b. diagnostic laboratory and X-ray services;
 - c. oxygen and/or rental of equipment required for its administration;
 - d. X-ray, radium and radioactive isotope therapy;
 - e. braces, crutches, casts and splints;
 - f. blood or other fluids actually injected into the circulatory system;

3. If a Covered Person incurs medically necessary expenses which are recommended and approved by a Physician for private-duty nursing services outside of a hospital, the Plan shall pay for such private-duty nursing charges not exceeding the maximum amount specified in the Schedule of Benefits for such charges. Private-duty nursing services shall be payable only if provided by a Registered Nurse (R.N.). If the services of an R.N. are not available, a Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.) or a Registered Nurse Midwife acting within the scope of his license.
4. Initial artificial limbs, eyes (including the first pair of contact lenses following cataract surgery, and prescription lenses for Covered Persons lacking organic lenses) and prosthetic appliances (other than dental prosthetics); and replacement of such artificial limbs, eyes or prosthetic appliances, if necessitated due to pathological changes or normal growth.
5. The initial purchase only (up to a maximum Plan payment of \$500) of a wig to replace natural hair lost as a result of an illness, disease or accident, including loss of hair due to alopecia. (Contact Aetna prior to purchase as limitations may apply).
6. Rental (or purchase at the Plan's option) of Durable Medical Equipment prescribed by a Physician and required for therapeutic use in the treatment of an active illness or injury.

Local transportation by a professional ambulance service, or organized voluntary ambulance service, to the nearest hospital or other medical institution for covered medical treatment.

7. Charges for expenses by an ambulatory care center, to the extent such expenses would have been covered if provided by a hospital as part of an inpatient confinement.
8. Dental care or treatment due to accidental injury to sound natural teeth within 12 months of the accident or necessary due to congenital disease or anomaly.
9. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
10. Services by duly licensed podiatrists or licensed Physicians for treatment of diseases, injuries, and malformations of the foot. There are two general exceptions: treatment of weak, strained or flat foot, of any instability or imbalance of the foot, or of any metatarsalgia or bunion is not covered, however, if a cutting operation is used, such treatment will be covered; and treatment of corns, calluses or toenails, including cutting or removal thereof is not covered, however, if such treatment is prescribed by a Doctor of Medicine (M.D.) who is providing treatment for a metabolic disease (such as diabetes mellitus) or a peripheralvascular disease (such as atherosclerosis), it will be covered.
11. Charges related to voluntary sterilization, including Physician and hospital or other facility charges.
12. Maternity care including inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth (96 hours following a cesarean section). If the mother is discharged earlier than the recommended time frames described above, coverage of one home health care visit rendered by a home health agency that is:
 - (a) an agency or hospital that has been issued a certificate as a certified home health agency (CHHA) by the New York State Department of Health to provide home health services; or

(b) if outside of New York State, a home health agency that meets the same criteria required to obtain the certificate in New York State.

A home health maternity care visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean delivery). The visit must be rendered within 24 hours after discharge or of the time of the request, whichever is later.

The home health maternity care visit is not subject to deductible, coinsurance or co-payment if billed separately from the hospital's charges for maternity care services.

Maternity care also includes parent education, assistance and training in breast or bottle-feeding, the performance of any necessary maternal and newborn clinical assessments and the services of a midwife.

13. Charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. For non-preferred providers, the patient's financial responsibility shall be limited to the amount he would have paid had the provider been a preferred provider.
14. Charges for breast reconstruction after a mastectomy in the manner determined by the attending physician and the patient to be appropriate. This includes (a) all stages of reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications of mastectomy, including lymphedemas.
15. For diabetic patients, the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin diffusion devices and oral agents for controlling blood sugar.

Coverage shall also include diabetes self-management education to ensure that persons with diabetes are educated to the proper self-management and treatment of their diabetic condition including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnosis a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self management or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law or their staff, as part of an office visit for diabetes diagnosis or treatment or by a certified diabetes nurse educator, certified nutritionists, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

16. Charges for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health law. Deductibles, coinsurance and/ or co-payments shall apply.

17. a. Coverage shall not be excluded for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.
- b. Benefits are payable for charges for hospital care, surgical or medical procedures or prescription drugs which would correct malformation, disease or dysfunction resulting in infertility, diagnostic tests and procedures, including prescription drugs necessary to determine infertility or that are necessary in connection with hospital care or surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Coverage shall not include diagnosis or treatment in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental.
- c. Paragraph b above is limited to individuals whose ages range from twenty-one (21) through forty-four (44), and whose diagnosis and treatment has been prescribed as part of a physician's overall plan of care.

Charges for services provided by a comprehensive care center for eating disorders pursuant to Article Twenty-Seven J of the Public Health Law, unless otherwise excluded.

OUTPATIENT SHORT-TERM REHABILITATION

The charges made by:

- a physician; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy;
- speech therapy; or
- spinal manipulation,

furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Short-term rehabilitation services must be provided in accordance with a specific plan specified by a physician that details the treatment to be rendered and the frequency and duration of the treatment, provides for ongoing reviews and is renewed only if therapy is still necessary.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.

- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a physician or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from disease; injury; or congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.

Outpatient short-term rehabilitation services shall be subject to deductibles, co-payments and/or coinsurance.

Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal illness, and **all** of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for "routine patient costs" furnished in connection with your participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations:

Not covered under this Plan are:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

These Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations, and exclusions of this Plan including, but not limited to, any precertification and referral requirements.

PREVENTIVE SERVICES

Please refer to Appendix A for the Plan's Preventive Services Benefit coverage

MANAGED BENEFITS PROGRAM

The Managed Benefits Program, as described in the Managed Benefits Program chapter of this Plan Document, shall be equally applicable to Medical Expense Benefits portion of the Plan to the extent that the specific types of services to which the Program applies are also considered covered Medical Expense Benefits. The penalties specified for non-compliance with the Admission Review Program shall also be applicable to Medical Expense Benefits.

PRESCRIPTION DRUG EXPENSE BENEFITS

If you are covered under the Consortium's Medicare Part D Prescription Drug Plan, there may be slight variations from the plan provisions noted below. Please consult your Evidence of Coverage (EOC) document provided by SilverScript for specific information about that plan's benefits and coverage.

The Prescription Drug Expense Benefits portion of the Plan is a separate coverage from the Medical Expense Benefits. However, in addition to the exclusions indicated below, all provisions and limitations of the Plan shall apply to this coverage. The Plan shall not exclude coverage of any drug approved by the FDA for the treatment of certain types of cancer on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

- (i) the American Medical Association Drug Evaluations;
- (ii) the American Hospital Formulary Service Drug Information; or
- (iii) the United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Coverage shall not be provided for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed unless directed to pursuant to an external appeal. Covered expenses paid under this portion of the Plan shall not be a benefit under any other portion or coverage of the Plan.

CO-PAYMENT

The co-payment amount shall be the amount per prescription specified in the Schedule of Benefits which shall not be considered a covered expense. Payment of the co-payment amount per prescription shall be the responsibility of the Covered Person.

Note: Once your aggregate maximum co-payment per individual or family (please refer to the Schedule of Benefits) is met, further co-payments will be waived.

COVERED DRUGS

Covered Drugs include only the following:

1. Legend drugs,
2. Insulin on prescription.
3. Tretinoin, all dosage forms (e.g., Retin-A). For individuals over age 25, documentation verifying medical necessity must be submitted to Aetna before reimbursement will be made.
4. Compounded medication of which at least one ingredient is a prescription legend drug; subject to Prior Authorization.
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

6. Nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenyl Ketonuria, branched-chain Ketonuria, galactosemia and momocystinuria as administered under the direction of a physician.
7. Syringes and needles for diabetic use.
8. Enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated cause chronic disability, mental retardation or death. Specific diseases for which enteral formulas have proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohns's Disease, gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.
9. Prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility, except that coverage shall not include prescription drugs in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental. Coverage is limited to individuals whose ages range from twenty-one (21) through forty-four (44) years.
10. Drugs for bone density as approved by the federal Food and Drug Administration (FDA).
11. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary, and such coverage for such modified solid food products shall not exceed \$2,500 per person per calendar year.
12. Drugs or devices for the treatment of erectile dysfunction; subject to a maximum of 6 pills per month.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

EXCLUSIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

In addition to the General Limitations of the Plan, no benefits shall be payable under the Prescription Drug Expense Benefits portion of the Plan for the following:

1. Non-legend drugs;
2. Charges for the administration or injection of any drug.
3. Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use, unless otherwise covered under this Plan or required by law.
4. Prescriptions if benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law;
5. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual unless directed pursuant to an External Appeal;

6. Immunization agents, unless specifically included, biological sera, blood or blood plasma;
7. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
8. Any prescription refilled in excess of the number specified by the Physician or allowed by the Plan, or any refill dispensed after one year from the Physician's original order;
7. Drugs that are available without a prescription, unless otherwise specifically included;
8. For Medicare primary eligible members only: Drugs that are covered under Medicare Part B must first be processed by Medicare. Secondary claims may then be submitted to Aetna under the medical portion of the plan.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

DISPENSING LIMITATIONS

The amount normally prescribed by Physician, but not to exceed a 30-day supply, except when a maintenance drug is ordered from the Plan's mail order pharmacy vendor. Maintenance medications dispensed through the mail order vendor are limited to a maximum of a 90-day supply.

NON-PARTICIPATING (PHARMACY) PROVIDERS

If you obtain covered prescription drugs from a pharmacy which does not participate in the Plan's Prescription Drug Expense Benefits program through CVS Caremark, the Plan's payment for such covered prescription drugs shall be limited to the amount the Plan would have paid had such prescription drugs been purchased from a participating pharmacy.

You may obtain a special prescription drug claim form from your District Benefit Representative or the Consortium's website to file a claim for prescriptions purchased from pharmacies that do not accept the CVS Caremark card.

MAIL ORDER PHARMACY

The Consortium utilizes CVS Caremark to administer a Home Delivery Prescription Drug Program for maintenance or long term use drugs. The mail order program is completely optional. CVS Caremark Home Delivery mail order kits can be obtained from your School District business or personnel office.

In addition, maintenance prescriptions of which a 90-day supply is permitted at mail order may also be obtained from local CVS Caremark pharmacies.

PRESCRIPTION DRUG COORDINATION OF BENEFITS

If the Consortium's Plan is not the primary payer, the claim may still be adjudicated at the pharmacy. Show your primary prescription drug card and your CVS Caremark card to the pharmacy and ask that both primary and secondary claims be processed. If the pharmacy does not process your secondary claim, you may submit a secondary claim, including itemized receipt and evidence of the primary payers explanation of benefits to CVS Caremark.

CVS Caremark
Attn: Claims Department
P.O. Box 52136
Phoenix, Az. 85072-2136

CERTIFICATION FOR CERTAIN PRESCRIPTION DRUGS

Certification of the necessity of certain prescription drugs is required before the drug may be dispensed by a pharmacy.

CERTIFICATION PROCEDURES

It is your responsibility to arrange for the prescriber of the drug to call CVS Caremark at **1-800-294-5979** to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

CVS Caremark will notify you and your healthcare provider of the decision, in writing, within three (3) business days of receipt of the necessary information. If the certification request is denied, this notice will provide the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

LIST OF PRESCRIPTION DRUGS REQUIRING CERTIFICATION

The following **prescription drugs** require certification before the drug is dispensed:

- Appetite suppressants/ weight loss medications
- Specialty drugs (e.g. growth hormones, Multiple Sclerosis agents, Hepatitis C agents, Rheumatoid Arthritis agents)
- Retin-A (over age 25)
- Non-formulary drugs

Contraceptive Drugs or Devices

Coverage shall be provided for the cost of contraceptive drugs or devices approved by the federal Food and Drug Administration or generic equivalents approved as substitutes by such administration under the prescription of a health care provider legally authorized to prescribe.

Coverage shall be subject to deductibles and coinsurance or co-payments.

LIMITATIONS

GENERAL LIMITATIONS

No benefits shall be payable under the Plan, unless specifically listed as covered, with respect to:

1. Services or expenses incurred prior to the effective date or after the termination date of coverage under the Plan.
2. Any services, supplies, charges or expenses which are not specifically included and listed as covered expenses under a portion of the Plan for which the Covered Person is eligible, including any charge or portion of a charge which is in excess of the usual, reasonable and customary charges as defined by the Plan.
3. Services or supplies that are, as determined by the Plan, to be experimental or investigational, unless otherwise directed pursuant to an External Appeal. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

if required by the FDA, approval has not been granted for marketing; or

a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

4. Any services not necessary, as determined by the Plan, for diagnosis, care or treatment of an illness or injury; except that circumcisions, abortions, vasectomies and tubal ligations shall be covered as if related to an illness.
5. Any treatment or service not prescribed or recommended by a Physician or other provider of service defined as eligible for payment by the Plan.
6. Any charges for hearing aids or their repairs, eye glasses, eye examinations, correction (including surgical) of vision.
7. Any services/treatments for which benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law.
8. Charges for any care or treatment of teeth, gums or alveolar process unless such charges are for:
 - a. reduction of fractures of the jaw or facial bones;
 - b. surgical correction of cleft lip, cleft palate, or protruding mandible;
 - c. removal of stones from salivary ducts;
 - d. bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;
 - e. freeing of muscle attachments; or
 - f. charges for dental care or treatment except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
9. Those for cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
10. Expenses incurred for the treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral-vascular disease.
11. Expenses incurred for Custodial Care Services.
12. Expenses incurred for orthopedic shoes, orthotics and other supportive appliances for the feet.
13. Any illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection or service in the Armed Forces or units auxiliary thereto.
14. Any charges for care or treatment provided or furnished by the United States Government or the government of any country, except to the extent that federal or state law requires the Plan to provide benefits for such care or treatment.

15. Any services for which a charge would not have been made in the absence of coverage, except to the extent that federal law requires the Plan to provide benefits for such services.
16. Any expenses or charges that the member or patient is not legally responsible to pay for.
17. Hospice Care, services or expenses that cannot reasonably be expected to lessen the patients disability and to enable him to live outside of an institution.
18. Charges for services/treatment for which an adequate claim is not filed with the Claims Administrator within 15 months from the date of service.
29. Expenses for prescription drugs or medicines prescribed for use on an out-patient basis, except to the extent specifically listed as covered expenses under the Plan's Prescription Drug Expense Benefits.
20. Any charges for services/treatment related to weight reduction, unless medically necessary or for the treatment of morbid obesity.
21. Any charges for services/treatment related to an accident, to the extent that benefits for such services/treatment are paid/payable or recovered/recoverable through/from mandatory automobile no-fault insurance coverage.
22. Any charges for services provided by a member of the patient's immediate family.
23. Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
24. Charges/ expenses for acupuncture therapy except acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered by the Plan.
25. Services to the extent for which an employee, retired employee or dependent:
 - A. Is entitled to benefits under either Part A or Part B of Medicare, or,
 - B. Would have been entitled to benefits under Part A or Part B of Medicare, except that, although being eligible, failed to enroll for the benefits, or
 - C. Would have been entitled to benefits under Part B of Medicare, but having enrolled, failed to continue to make payment of the premiums thereof.
 - D. Would have been entitled to benefits under Part A or B of Medicare had the provider not opted out of Medicare.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys’ fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

MISCELLANEOUS PROVISIONS

THE COORDINATION OF BENEFITS PROVISION

ORDER OF PAYMENT

When you are covered by more than one health care plan to which the Coordination of Benefits provision applies, (including when you are covered by this Plan as both an employee/retiree and as a dependent) the rules below are followed to determine which plan will be the first to pay its benefits:

The order of benefit payments is determined using the first of the following rules which applies:

1. NON-DEPENDENT / DEPENDENT

- a. The benefits of a plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of a plan which covers the person as a dependent or COBRA Extensee, except if the person is a Medicare beneficiary;
- b. If the covered individual is a Medicare beneficiary, then Medicare is:
 - i. primary to the plan(s) covering the person as a retiree, or as the dependent of a retiree; and
 - ii. secondary to the plan(s) covering the person as an active employee or as the dependent of an active employee.

Note: special rules apply when a person is covered by Medicare and has End State Renal Disease

2. DEPENDENT CHILD / PARENTS NOT SEPARATED OR DIVORCED

- a. The benefits of the plan of the parent whose birthday falls earlier in a year as determined before those of the plan of the parent whose birthday falls later in that year, but
- b. if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

Note: The word birthday refers only to month and day in a calendar year, not the year in which the person was born. This is known as the "birthday rule".

- c. 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 benefits.

3. DEPENDENT CHILD / SEPARATED OR DIVORCED PARENTS

- 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; and
- d. if the specific terms of a court decree state that one of the parents is responsible 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 or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. ACTIVE / INACTIVE EMPLOYEE

The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent) or COBRA Extender. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph is ignored.

5. LONGER / SHORTER LENGTH OF COVERAGE

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered the person for the shorter time.

- a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:
 - i. a change in the amount or scope of a plan's benefits;
 - ii. a change in the entity which pays, provides or administers the plan's benefits; or
 - iii. a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
- 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, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

In the event that this Plan is secondary payer but the other Plan contains a provision that states it is excess or always secondary or uses order of benefit determination rules which are inconsistent with the rules of this section, then this Plan shall pay its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary Plan. Such payment shall be the limit of this Plan's liability.

HOW YOUR BENEFITS ARE PAID

The plan which is the first to determine its benefits will pay its benefits without regard to any other coverage.

When this plan is secondary to another plan that is primary, we will first calculate the benefit AS IF THIS PLAN WAS PRIMARY. The benefit will then be reduced by the amount paid by the other plan. This method of coordination is referred to as Maintenance of Benefits.

The following examples illustrates this:

<p>Example 1: Doctor is out of Aetna's network</p> <p>Non-participating doctor's charges = -----</p> <p>Reasonable & Customary = -----</p> <p>This plan, IF Primary, would pay (@80%) = -----</p> <p>Other primary plan pays (@70%) = -----</p> <p>This plan will pay (\$400-350) = -----</p> <p>Member is responsible for = -----</p>	<p>\$550</p> <p>\$500</p> <p>\$400</p> <p>\$350</p> <p>\$50</p> <p>\$150</p>
<p>Example 2: Doctor is in Aetna's network</p> <p>Aetna-participating doctor's charges = -----</p> <p>Reasonable & Customary =-----</p> <p>Aetna's negotiated fee = -----</p> <p>This plan, IF Primary, would pay (\$400-\$20 co-payment) =-----</p> <p>Other primary plan pays (@70%) =-----</p> <p>This plan will pay (\$380-350) =-----</p> <p>Member is responsible for = -----</p>	<p>\$550</p> <p>\$500</p> <p>\$400</p> <p>\$380</p> <p>\$350</p> <p>\$30</p> <p>\$20</p>
<p>Example 3: Medicare Parts A & B are primary</p> <p>Doctor is in Aetna's network and accepts Medicare assignment:</p> <p>Charges = -----</p> <p>Medicare allows = -----</p> <p>This plan, IF Primary, would pay (\$400# -\$20 co-payment) = -----</p> <p>Medicare pays (@80% * \$400) = -----</p> <p>This plan will pay (\$400-\$320-\$20) = -----</p> <p>Member is responsible for = -----</p> <p># Doctors accepting Medicare assignment must reduce their charges to the amount Medicare allows.</p>	<p>\$550</p> <p>\$400</p> <p>\$380</p> <p>\$320</p> <p>\$60</p> <p>\$20</p>
<p>Medicare Advantage – Medicare Advantage combines the benefits of Medicare Parts A and B and the Aetna supplemental coverage into a single package. Medicare Advantage is Medicare Part C.</p>	

When you are covered under more than one health plan you should not be expected to pay any more than you would have paid had you been covered under only one plan. To illustrate this, assume that you visit an Aetna Choice POS II provider, Aetna is secondary payer and the provider does not participate with the primary plan.

Doctor's charges	\$150
Primary plan allows	\$120
Primary plan pays @ 80%	\$ 96

If the primary plan is your only plan, you would be responsible to the doctor for \$54 (\$150-\$96). If Aetna Choice POS II was your only plan, you would be responsible for a \$20 co-payment. Therefore, you should be responsible for the \$20 co-payment after the doctor was paid \$96 by the primary plan.

EFFECTS OF MEDICARE

Most Medicare eligible members covered by the Consortium will be enrolled in the Consortium's Medicare Advantage plan (Medicare Part C) provided by Aetna and the Medicare Prescription Drug Plan (Medicare Part D) provided by CVS Caremark. Members enrolled in the Medicare Advantage medical plan/Medicare drug plan should refer to separate plan documents provided by Aetna and CVS Caremark that addresses the benefits of those plan.

For members who are enrolled in original Medicare Parts A & B:

- Part A generally covers hospital care,
- Part B generally covers physician services

Important Note:

The Plan will not provide any benefits an Employee, Retiree or Dependent is, or could have been, eligible to receive from Medicare Parts A, B, or C whether or not that person has enrolled in Part A, Part B, or Part C of Medicare, regardless of age, if Medicare would be primary to this plan. This means individuals who are eligible for Medicare due to age or disability or End Stage Renal Disease*. Consequently, to avoid a drastic reduction in health benefits, it is essential that each eligible Retiree or Retiree's Dependent be enrolled in both Part A and Part B of Medicare or Medicare Part C (Medicare Advantage) if Medicare would be primary to this Plan.

- * The coordination methodology for members eligible for Medicare due to End Stage Renal Disease is different than for members eligible due to age or disability.

In the case of Retired Medicare-eligible Employees (includes those not actively at work), and their covered Medicare-eligible dependents, the Plan's normal Coordination of Benefits provisions shall not apply; Medicare Parts A & B, or Part C shall be the primary provider of coverage. The Plan will reduce its benefits payable by any amount(s) paid or payable by Medicare/Medicare Advantage. In the event such a Medicare-eligible individual chooses not to enroll for Medicare coverage (Parts A & B, or C), this Plan's payment will still be based on the amount(s) Medicare would have paid had the individual elected coverage under both Parts A & B, or C of Medicare.

In the event that a member receives services from a provider who opted out of Medicare Parts A and/or B and/or C, the Plan shall pay no more than it would have paid had the provider accepted Assignment under parts A and B.

See the Prescription Drug portion of the plan for information about drugs covered under Medicare Part B.

IF YOU HAVE ANY QUESTIONS ABOUT HOW YOUR STATUS AFFECTS THIS PLAN'S COORDINATION WITH MEDICARE, CONTACT THE OFFICE OF RISK MANAGEMENT.

GENERAL INFORMATION

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

The Putnam/Northern Westchester Health Benefits Consortium administers a health plan to reimburse non-occupational illness and injury claims through contract administration by third-party claims administrators.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

Risk Manager
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

Joint Governance Board
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

NAME AND ADDRESS OF THE MEDICAL CLAIMS ADMINISTRATOR

AETNA
P. O. Box 981109
El Paso, TX 79998-1109

NAME AND ADDRESS OF THE PRESCRIPTION DRUG CLAIMS ADMINISTRATOR*

Excludes prescriptions filled through CanaRx

CVS Caremark
P.O. Box 52136
Phoenix, Arizona. 85072-2136
Attn: Claims Department

DESCRIPTION OF RELEVANT PROVISIONS OF ANY APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The current applicable collective bargaining agreements are between the various participating School Districts and their collective bargaining units and/or unions representing Employees eligible to participate in the Plan. An Employee may obtain a copy of any such bargaining agreement applicable to him from his Employer.

DATES OF THE PLAN YEAR

July 1st through the following June 30th

INTERNAL REVENUE SERVICE TAX IDENTIFICATION NUMBER

Tax Identification Number 13-3962250

CMS HEALTH INSURANCE OVERSIGHT SYSTEM HEALTH PLAN IDENTIFICATION NUMBER

HPID 7679576422

PLAN AMENDMENT/TERMINATION PROCEDURE

The Joint Governance Board, by a majority decision and as authorized by the Trustees under separate agreement, may alter, change or amend any Plan coverage or benefit if such change, modification or amendment is determined to be required for the prudent administration of the Plan. Any decisions of the Joint Governance Board shall be binding upon all members of the Plan. This includes, but is not limited to, active employees, retirees, dependents of employees and retirees, and beneficiaries of Continued Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

Appendix A

PREVENTIVE SERVICES

A. Preventive Services for Members; Birth to Age 21

Preventive pediatric health care services recommended by the American Academy of Pediatrics (AAP) to age 21. Visits may include physical measurements, patient history, sensory screenings, behavioral assessments, and planned procedures (immunizations, screenings and other tests). Please refer to the AAP website for additional information and frequency:

<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>

These services will not be subject to deductibles and coinsurance or copayments.

B. Preventive Services for Members; Age 21 and Older

The preventive services listed below will be available to all members age 21 and older. These services will not be subject to deductibles and coinsurance or copayments.

Physician counseling and screenings.

- Abdominal Aortic Aneurysm
- Alcohol Misuse
- Aspirin
- Blood Pressure
- Cholesterol
- Colorectal Cancer screening for adults over 50
- Depression
- Type 2 Diabetes
- Diet counseling for adults at higher risk for chronic disease
- HIV
- Obesity
- Sexually Transmitted Infection (STI)
- Tobacco Use
- Syphilis

Physician counseling and screenings for Women.

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography

(a) upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

(b) a single baseline mammogram for covered persons aged thirty-five through thirty-nine inclusive;

(c) an annual mammogram for covered persons aged forty and older.

- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding
- Cervical Cancer
- Chlamydia Infection
- Contraception
- Domestic and interpersonal violence
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV)
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis Coverage shall apply for individuals meeting the criteria for coverage under the federal Medicare program or the criteria for coverage under the National Institutes of Health (NIH), and include individuals (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis, (b) with symptoms or conditions indicative of the presence or the significant risk of osteoporosis, (c) on a prescribed drug regimen, (d) with lifestyle factors to such a degree posing a significant risk of osteoporosis, or (e) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use
- Sexually Transmitted Infections (STI)
- Syphilis

C. Immunizations for Members; Birth to Age 26

The Plan will cover immunizations for members to age 26 as recommended by the Advisory Committee on Immunization Practices (ACIP). These services will not be subject to deductibles and coinsurance or copayments. Please refer to the ACIP website for an up to date listing of recommended immunizations: <http://www.cdc.gov/vaccines/recs/schedules/default.htm>

D. Immunizations for Members; Age 26 and Older

The immunizations specified by the Advisory Committee on Immunization Practices (ACIP) will be available to members age 26 and older. These services will not be subject to deductibles and coinsurance or copayments. Please refer to the ACIP website for an up to date listing of recommended immunizations: <http://www.cdc.gov/vaccines/recs/schedules/default.htm>

Vaccine ↓ Age ►	26-49 years	50-64 years	65 years and older
Influenza	You need a dose every fall (or winter for your protection and for the protection of others around you.	You need a dose every fall (or winter for your protection and for the protection of others around you.	You need a dose every fall (or winter for your protection and for the protection of others around you.
Pneumococcal	You need 1-2 doses if you smoke cigarettes or if you have certain chronic medical conditions.	You need 1-2 doses if you smoke cigarettes or if you have certain chronic medical conditions.	You need 1 dose at age 65 (or older) if you've never been vaccinated.
Tetanus, diphtheria, pertussis (whooping cough) (Td, Tdap)	Be sure to get 1-time dose of "Tdap" vaccine (the adult whooping cough vaccine) if you are younger than age 65 years, are 65+ and have contact with an infant, are a healthcare worker, or simply want to be protected from whooping cough. You need a Td booster dose every 10 years. Consult your healthcare provider if you haven't had at least 3 tetanus and diphtheria containing shots sometime in your life or have a deep or dirty wound.	Be sure to get 1-time dose of "Tdap" vaccine (the adult whooping cough vaccine) if you are younger than age 65 years, are 65+ and have contact with an infant, are a healthcare worker, or simply want to be protected from whooping cough. You need a Td booster dose every 10 years. Consult your healthcare provider if you haven't had at least 3 tetanus and diphtheria containing shots sometime in your life or have a deep or dirty wound.	Be sure to get 1-time dose of "Tdap" vaccine (the adult whooping cough vaccine) if you are younger than age 65 years, are 65+ and have contact with an infant, are a healthcare worker, or simply want to be protected from whooping cough. You need a Td booster dose every 10 years. Consult your healthcare provider if you haven't had at least 3 tetanus and diphtheria containing shots sometime in your life or have a deep or dirty wound.
Hepatitis B (HepB)	You need this vaccine if you have a specific risk factor for hepatitis B virus infection or you simply wish to be protected from this disease. This vaccine is given in 3 doses, usually over 6 months.	You need this vaccine if you have a specific risk factor for hepatitis B virus infection or you simply wish to be protected from this disease. This vaccine is given in 3 doses, usually over 6 months.	You need this vaccine if you have a specific risk factor for hepatitis B virus infection or you simply wish to be protected from this disease. This vaccine is given in 3 doses, usually over 6 months.
Hepatitis A (HepA)	You need this vaccine if you have a specific risk factor for hepatitis A	You need this vaccine if you have a specific risk factor for hepatitis A	You need this vaccine if you have a specific risk factor for hepatitis A

	virus infection or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses, 6-18 months apart.	virus infection or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses, 6-18 months apart.	virus infection or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses, 6-18 months apart.
Human papillomavirus (HPV)	Generally covered if you are age 26 years or younger.		
Measles, mumps, rubella (MMR)	You need at least 1 dose of MMR if you were born in 1957 or later. You may also need a 2 nd dose.		
Varicella (Chickenpox)	If you've never had chickenpox or you were vaccinated but received only 1 dose, talk to your healthcare provider to find out if you need this vaccine.	If you've never had chickenpox or you were vaccinated but received only 1 dose, talk to your healthcare provider to find out if you need this vaccine.	If you've never had chickenpox or you were vaccinated but received only 1 dose, talk to your healthcare provider to find out if you need this vaccine.
Meningococcal	If you are going to college and plan to live in a dormitory, or have one of several medical conditions, you need to get vaccinated against meningococcal disease. You may also need additional booster doses.		
Zoster (shingles)		Generally covered if you are age <u>50-years</u> or older.	Generally covered if you are age <u>50-years</u> or older.

Appendix B

APPEALS/ GRIEVANCES/ COMPLAINTS

Definitions

Adverse benefit determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a Plan benefit, supply or benefit because it is determined to be experimental or investigational or not medically necessary or appropriate.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage ;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination**.

Health care provider: A health care professional or facility licensed pursuant to New York law or licensed, registered or certified by another state.

Complaint: A written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services.

Expedited Appeal: Appeal of an **adverse benefit determination** involving (1) continued or extended health care services, procedures and treatments or additional services for a covered person undergoing a course of continued treatment prescribed by a health care provider, or (2) an **adverse benefit determination** in which the health care provider believes an immediate appeal is warranted where there is imminent or serious threat to the health of the insured, except any retrospective determination.

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination** or **complaint**

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the person or the ability of the person to regain maximum function; or (b) in the opinion of a physician with knowledge of the person's medical condition would subject the person to severe pain that cannot be adequately managed without the requested treatment.

When a claim is denied in full or in part:

Step 1 Initial Actions to Take

A Health Plan member is entitled to know why a claim has been denied or partially paid.

When you receive a denial or a partial payment for a claim which you believe should have been paid differently, you should do the following:

- * Review your Benefits Plan Booklet.
- * Call the claims administrator using the applicable toll-free numbers shown on your ID Cards.
- * Discuss the paragraphs from the Plan Booklet pertaining to the coverage denied with the claims processing representative.

Most denied or partially paid claims are resolved to the member's satisfaction by reviewing the Plan Booklet and the facts of the claim. Claims that may have been initially processed inappropriately are usually either corrected by this point or the situation is more fully explained to the claimant by the claims processing representative at the claims administrator

Medical/Hospital Claims Administrator Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106	Prescription Drug Claims Administrator CVS Caremark Prescription Claim Appeals, MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172
---	---

Please keep in mind that most steps of the process have strict time limits that must be followed. Your appeal/grievance/complaint will be rejected if you fail to comply with the specified time limits. Unless otherwise noted, "days" means calendar days.

If you are not satisfied at this point, proceed to step 2.

2 Claim Determinations

Urgent Care Claims

The Claims Administrator will make notification of a claim determination as soon as possible, but not later than 72 hours after receipt of the necessary information.

Pre-Service Claims

The Claims Administrator will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the necessary information. In the event you fail to provide all of the necessary information for the administrator to make a claim determination, you will be allowed 45-days to submit the necessary information, and a claim determination will be made within 15 days after receipt of such information. If the information requested is not received within 45 days, a determination will be made based on information available and you will be notified of the decision within 15 days. You or your designee and your **Health Care Provider** will be notified of the determination in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, the Claims Administrator will generally make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** within 24 hours after receipt of the necessary information.

Post-service Claims

The Claims Administrator will make notification of a claim determination in writing within 30 days after receipt of the necessary information.

The Notice of **adverse benefit determination** will include:

- The reasons for the **adverse benefit determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the plan's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse benefit determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on **appeal**.

In the event that the Claims Administrator renders an **adverse benefit determination** without first attempting to discuss the matter with the insured's **health care provider** who specifically recommended the service, procedure or treatment, the **health care provider** will have the opportunity to request a reconsideration of the adverse benefit determination. Except for post-service claims, such reconsideration will occur within 1 business day of receipt by the Claims Administrator of the request. If the **adverse benefit determination** is upheld, the Claims Administrator will provide notice, as described above.

If the Claims Administrator does not render a decision within the period set forth above, you may consider this to be an **adverse benefit determination**, subject to **appeal**.

Proceed to Step 3 if you are appealing a claim that was denied, or reduced in part, because it has been deemed to be not medically necessary/appropriate, has been deemed to be experimental or investigative.

Proceed to Step 4 if you are appealing a claim denied or reduced for a reason other than medical necessity/appropriateness or being experimental/investigative.

Proceed to Step 5 if you are addressing a concern not included under steps 3 or 4.

Step 3 Appeals of Adverse Benefit Determinations

You may submit an **appeal** if the Claims Administrator gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted orally or in writing. The request should include:

- Your name;
- Your employer's name;
- A statement from your physician;

A copy of Aetna's notice of an **adverse benefit determination**;
Your reasons for making the **appeal**; and
Any other information you would like to have considered.

Send your **appeal** to the Claims Administrator's Customer Service Department at the following address, or call in your **appeal** to Customer Service using the toll-free telephone number.

Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106 1-877-223-1685	CVS Caremark Prescription Claim Appeals, MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172
--	---

You may also choose to have an authorized designee make the **appeal** on your behalf by providing written consent to the Claims Administrator. Your **health care provider** may make the appeal in connection with the **adverse benefit determination** for a **post service claim**.

A. Level One Appeal

A level one **appeal** of an **adverse benefit determination** shall be decided by the Claims Administrator personnel not involved in making the **adverse benefit determination**.

Expedited Appeals

The Claims Administrator has established an expedited **appeals** process for adverse **benefit determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims**. The Claims Administrator will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within 36 hours of receipt of the necessary information to conduct the **appeal**.

Standard Appeals

The Claims Administrator shall issue a decision within 30 days of receipt of the necessary information to conduct the **appeal**. Aetna will provide written acknowledgement of the filing of the **appeal** within 15 days of its receipt.

The notice of the appeal determination will include:

- If the **adverse benefit determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external **appeals** process. You also have the option to request a Level 2 **appeal** from the Claims Administrator.

If the Claims Administrator does not render an appeals determination within 60 days after receipt of the information necessary to conduct the appeal, the adverse benefit determination will be reversed.

B. Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Claims Administrator has denied coverage on the basis that the a)service is not medically necessary or is an experimental or investigational treatment or (b) if applicable, such service is out-of network and an alternate is available in-network, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State Department of Financial Services to conduct such appeals.

Your Right to Appeal a Determination that a Service is not Medically Necessary

If the Claims Administrator has denied coverage on the basis that the service is not medically **necessary**, you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of the Claims Administrator internal review process and the Claims Administrator must have upheld the denial or you and the Claims Administrator must agree in writing to waive any internal appeal.

Your Right to Appeal a Determination that a Service is Experimental or Investigational or

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of the Claims Administrator internal **appeal** process and the Claims Administrator must have upheld the denial or you and the Claims Administrator must agree in writing to waive any internal **appeal**.

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

Your attending **physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this plan or one for which there exists a clinical trial or rare disease treatment (as defined by law.)

In addition, your attending **physician** must have recommended at least one of the following:

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical

Expense (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or, in the case of a rare disease, based on the physician's certification and such other evidence as the insured, the insured's designee or the insured's attending physician may present, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure; or A clinical trial for which you are eligible (only certain clinical trials can be considered). For the purposes of this section, your attending **physician** must be a licensed, board certified or board eligible **physician** qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If, through the first level of the Claims Administrator internal **appeal** process, you have received a final **adverse benefit determination** upholding a denial of coverage on the basis that the service is not medically **necessary** or is an experimental or investigational treatment, you have 4-months from receipt of such notice to file a written request for an external appeal. If you and the Claims Administrator have agreed to waive any internal **appeal**, you have 4-months from the receipt of such waiver to file a written request for an external **appeal**. the Claims Administrator will provide an external appeal application with the final **adverse benefit determination** issued through the first level of the Claims Administrator internal **appeal** process or its written waiver of an internal **appeal**.

You may also request an external **appeal** application from the New York State Department of Financial Services at 1-800-400-8882. The completed application must be submitted to the New York State Department of Financial Services at the address listed in the application. If you satisfy the criteria for an external **appeal**, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the Claims Administrator based its denial, the External Appeal Agent will share this information with the Claims Administrator in order for it to exercise its right to reconsider its decision. If the Claims Administrator chooses to exercise this right, the Claims Administrator will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited **appeal** (described below), the Claims Administrator does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from you, your **physician** or the Claims Administrator. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within 2 business days.

If your attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 business days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and the Claims Administrator by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns the Claims Administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your responsibility to initiate the external **appeals** process. You may initiate the external **appeal** process by filing a completed External Appeal application with the New York State Department of Financial Services. You or your designee may file an external **appeal** application; but if it's filed by your designee, you must consent to it in writing. The Department of Financial Services may request from you written confirmation of the appointment of a designee. In addition, your attending **physician** has the right to pursue an external **appeal** of a retrospective **adverse claim determination**. To do so, the attending **physician** must complete an External Appeal application for health care providers. You must sign an acknowledgment of the request and a consent to release of any medical records.

Under New York State law, the completed request for **appeal** must be filed within 4-months of either: the date upon which you receive written notification from the Claims Administrator that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal **appeal**. The Claims Administrator has no authority to grant an extension of this deadline.

C. Level Two Appeal

If the Claims Administrator upholds an **adverse benefit determination** at the **first** level of appeal, you or your authorized representative have the option to file a **Level Two** appeal in lieu of an External Appeal, or while an External Appeal is in process. The **Level Two** appeal, if requested, must be submitted within 60 days following the receipt of notice of a Level One **appeal** determination.

A level two **appeal** of an **adverse benefit determination** of an **expedited appeal** shall be decided by Aetna personnel not involved in making the **adverse benefit determination**. A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Claims Administrator's Appeals Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)

The Claims Administrator shall issue a decision within 36 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an Expedited Appeal)

The Claims Administrator shall issue a decision within 15 days of receipt of the request for level two **appeal**.

Post-Service Claims

The Claims Administrator shall issue a decision within 30 days of receipt of the request for a level two appeal.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR PERSONS DIAGNOSED WITH ADVANCED CANCER

The following applies if a person: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the person's participating provider); and (ii) the participating provider, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the person's care would be appropriately provided by such facility.

In the event the Claims Administrator disagrees with the admission of or provision or continuation of care of the person by the facility, the Claims Administrator must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and the Plan will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

Step 4 Grievances

You may submit a **grievance** to the Claims Administrator within 180 days with respect to review of a determination **other than an adverse benefit determination**.

The Claims Administrator will acknowledge receipt of the **grievance** within 15 days after its receipt by the Claims Administrator.

Grievance Determinations

Expedited Grievances

the Claims Administrator will resolve an expedited **grievance** within 36 hours after receipt of all necessary information when delay would significantly increase the risk to a person's health.

Standard Grievances

For other **grievances**, the Claims Administrator will acknowledge receipt within 15 days and issue a determination within 30 days after receipt of the **grievance**, but not later than 45 days after receipt of all necessary information.

Grievance Appeals

Expedited Grievances

the Claims Administrator will render a decision within 36 hours after receipt of the grievance.

Standard Grievances

the Claims Administrator will acknowledge receipt within 15 days and issue a determination within 30 days after receipt of the grievance

If you still not satisfied with, you may proceed to Step 6 to submit your grievance to the Consortium's Joint Governance Board

Step 5 Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an in-network provider (if applicable), you must call or write the Claims Administrator's customer service department. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. The Claims Administrator will review the information and provide you with a written response within 15 days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

The Claims Administrator Customer Service telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within 1 business day after the call was recorded.

The Claims Administrator will summarize the nature of the complaint in writing. You will be required to sign a written acknowledgement of the **complaint**. **You must sign and return the acknowledgement, with any amendments, in order to initiate the complaint.** An acknowledgement letter will be sent to you within 15 days of the Claims Administrator's receipt of the **complaint**. This letter may request additional information. If so, the additional information must be submitted to the Claims Administrator within 15 days of the date of the letter.

If your complaint is still not resolved, you may proceed to Step 6 to submit your complaint to the Consortium's Joint Governance Board.

Step 6 Joint Governance Board

If, after complying with steps 4 or 5, your complaint or grievance has not been resolved, you may submit it to the Joint Governance Board for review. **Please note that the Joint Governance Board will NOT address Adverse Benefit Determinations, which are subject to Step 3.**

Submit all documentation that you wish to be reviewed by the Joint Governance Board, **within 60 days after receipt of the notice of determination from Step 4 or 5.** The Board will review your complaint or grievance at a regularly scheduled meeting and render a decision. The decision will be communicated to you, in writing within 15 days.

Documentation should be submitted to:

Joint Governance Board
Attn: Office of Risk Management
Putnam/ Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

If you are not satisfied with the Joint Governance Board's decision you may request a hearing before the Board.

- a. Your request for a hearing must be made in writing to the Joint Governance Board **within 60 days from the date of notice of the Joint Governance Board's decision.**

- b. The Board will determine if your request for a hearing will be granted. If granted, the Board will set a hearing date.
 - 1. Your complaint or grievance should be presented to the Board at the hearing by you and/or your personal representative.
 - 2. The Board will review all materials submitted through the hearing process and will provide you with a written response as to its determination within 15 days. That determination is final.

You may also submit appeals/grievances/complaints to the New York State Department of Financial Services, at either of the following addresses.

:

<p>Albany: Consumer Services Bureau NYS Department of Financial Services One Commerce Plaza Albany, NY 12257</p> <p>518-474-6600</p> <p>1 800 342 3736</p>	<p>New York City: Consumer Services Bureau NYS Department of Financial Services 25 Beaver Street New York, NY 10004-2319</p> <p>212-480-6400</p> <p>1 800 342 3736</p>
--	--

Additional information may be obtained from the Insurance Department's website:
<http://www.dfs.ny.gov/consumer/consindx.htm>

Appendix C

PRIVACY POLICY

THIS APPENDIX DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

In accordance with state and federal law, this notice is provided to inform you about the Putnam/ Northern Westchester Health Benefits Consortium Health Plan's (the Plan) policy to ensure the privacy of Protected Health Information (PHI). PHI is individually identifiable health information (IIHI) that relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

The Plan uses PHI to conduct its normal and necessary health plan operations. PHI may be shared with its Business Associates (third party vendors), such as Aetna Corp., when necessary and appropriate for member care or treatment, payment of claims and adjudication of appeals. It is the Consortium's policy that all uses and disclosures of PHI are minimized. Any party or entity to which the Consortium discloses PHI must have its own policies and procedures to ensure the privacy of PHI.

Uses and disclosures

The Plan and its Business Associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations or if required by law. The Plan may also disclose PHI to your employer (the Plan Sponsor) if such employer has agreed to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a pharmacist the types of medication you are taking to avoid an adverse medical reaction.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance related activities. It also includes disease management, case management, conducting or arranging for medical reviews, legal services and auditing functions including fraud and abuse detection programs, business planning and development and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefits costs or audit the accuracy of its third party administrators.

Other purposes we are permitted or required to use or disclose protected health information without written authorization include:

- **Public Health Activities**, such as for the purpose of preventing or controlling disease;
- Regarding **abuse, neglect or domestic violence**;
- **Health oversight agencies**, such as for criminal investigations;
- **Legal proceedings**, such as in response to a subpoena or court order;
- **Law enforcement** purposes, such as in response to a court ordered warrant or summons, or to avert a serious threat to someone's health and safety;
- **Coroners, Medical Examiners, Funeral Directors**, such as for the identification of a deceased person;
- **Organ procurement organizations** for the purpose of cadaver organ, eye or tissue donation;
- **Correctional or custodial institutions**, if necessary for the provision of care, the safety of the individual, other inmates or officers/ employees of the institution;
- **Workers' compensation**, if necessary to comply with applicable law.

Any other use or disclosure of your PHI will be made only with your written authorization. You may revoke such authorization in writing at any time.

Treatment, Payment and Health Care Operations may be delegated to third party administrators.

Your Rights

You have the right to request restrictions on certain uses and disclosures, however, the Plan is not required to agree.

You have the right to inspect, copy, or amend protected health information about you that is in a designated record set, subject to certain limitations.

You have the right to receive an accounting of any disclosures, except for disclosures necessary for treatment, payment or healthcare operations.

The Plan is required to abide by the terms of this notice. The Plan reserves the right to amend its policies and procedures, as necessary. If there is a material change in the Consortium's Privacy Policy, a revised notice will be distributed to employees and retirees via newsletter.

If you have any questions about this policy or believe that your rights have been violated, you may contact the Consortium's Privacy Contact Person by writing to:

Privacy Official
Putnam/ Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

You will not be retaliated against in any way for filing a complaint.