

THE EAST END HEALTH PLAN

PLAN DOCUMENT

Publication Date: August 1, 2002

INTRODUCTION

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

This booklet, which is also your Certificate of Benefits, describes in detail the health benefits coverage provided by the East End Health Plan. The Plan is coordinated by United Healthcare and includes the following basic elements of coverage:

- Hospitalization Coverage
- Managed Care Program
- Preferred Provider Program and Major Medical Coverage
- Prescription Drug Coverage
- Mail Order Prescription Drug Coverage
- Vision Care Benefits

You should familiarize yourself with the East End Health Plan by reading this booklet so that you will be able to use the benefits it provides most effectively. Pay particular attention to the information in Part II of this Plan Document about the Managed Care Program. Designed to control costs and provide you with the most appropriate health care, the Managed Care Program has requirements which must be met to obtain full benefits.

The East End Health Plan is online at WWW.EEHP.ORG. This website contains the most up-to-date information regarding the East End Health Plan, including an up-to-date online copy of this Plan Document. Also included on the website are:

- Bulletins & Special Announcements
- Forms
- Provider Listings
- Links to UHC & Caremark
- Other Useful Links
- Contact Information

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

If you want information about any aspect of the East End Health Plan or, if you need assistance in resolving a problem, you should first contact your District's Health Plan Coordinator. There you can obtain full information concerning your personal enrollment status as well as the eligibility requirements and benefit provisions of all enrollment options. Your District's Health Plan Coordinator will also assist you in resolving any claims problems you may encounter.

QUESTIONS ABOUT	CONTACT/ADDRESS	PHONE NUMBERS
<input type="checkbox"/> Enrollment	Your District's Health Plan Coordinator	the District's #
<input type="checkbox"/> Eligibility		
<input type="checkbox"/> Benefits, ID Cards		
<hr/>		
<input type="checkbox"/> Benefits Management	United Healthcare PO Box 740800 Atlanta, GA 30374-0800	1-888-607-5214
<input type="checkbox"/> Pre-Admission Certification		
<input type="checkbox"/> Second Surgical Opinion Program		
<input type="checkbox"/> Out-Patient Mental Health, Alcoholism and Substance Abuse Program		
<input type="checkbox"/> Mastectomy Second Medical Opinion Program		
<input type="checkbox"/> Managed Physical Medicine Program		
<hr/>		
<input type="checkbox"/> Hospitalization	United Healthcare PO Box 740800 Atlanta, GA 30374-0800	1-888-607-5214
<input type="checkbox"/> Preferred Provider Network		
<input type="checkbox"/> Medical Claims		

**NEED HELP? - HERE ARE THE ADDRESSES AND PHONE NUMBERS YOU NEED
(continued)**

QUESTIONS ABOUT	CONTACT/ADDRESS	PHONE NUMBERS
<input type="checkbox"/> Prescription Drug Retail Pharmacy	Caremark PO Box 52116 Phoenix, AZ 85072-2116	1-800-966-5772
<input type="checkbox"/> Prescription Drug Mail Order	Caremark PO Box 961066 Fort Worth, TX 76161-0066	1-800-966-5772
<input type="checkbox"/> Medicare	Contact your local Social Security Office - or -	1-800-772-1213
<input type="checkbox"/> Vision Plan	Davis Vision Vision Care Processing Unit PO Box 1525 Latham, NY 12110	1-800-999-5431

If you have difficulty reaching any of the above telephone numbers, call United Healthcare at 1-888-607-5214.

EAST END HEALTH PLAN

PART I

GENERAL INFORMATION

PART 1 - GENERAL INFORMATION

WHO IS ELIGIBLE?

This section explains eligibility requirements under the East End Health Plan for you (the enrollee) and your dependents. The East End Health Plan has established minimum eligibility requirements, which must be met by all employees of Districts that participate in the East End Health Plan; however, your employer may have adopted modified rules within specific limits.

MINIMUM REQUIREMENTS FOR ELIGIBILITY:

To be eligible for coverage, an employee must:

1. Be expected to work at least three months.
2. Work a regular schedule of 20 hours or more a week, **OR**
3. Be in one of the following categories:
 - A. A local elected official
 - B. A paid member of a public legislative body
 - C. An elected member of a school board
 - D. Be paid an annual salary at a rate of \$2,000 or more per year, **OR**
 - E. Receive your major source of family income from public employment.
4. Not already enrolled in the East End Health Plan as an employee. You are eligible for family coverage if you are enrolled under the program as a dependent of another District that is part of the East End Health Plan.

Note: The District may modify the minimum requirements in the following ways:

- By increasing the minimum period of anticipated employment from three months to as much as six months.
- By establishing a regularly scheduled workweek of more than 20 hours.
- By requiring a minimum annual salary of more than \$2,000.
- By excluding local elected officials, paid members of public legislative bodies or elected members of school boards, or by establishing workweek or annual salary-eligibility requirements for them.

YOUR DEPENDENTS: The following dependents are eligible for East End Health Plan coverage:

1. *Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.*
2. *Your unmarried children under 19 years of age are eligible. This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren. Other children who reside permanently with you in your household who are chiefly dependent on you are also eligible.*
3. *Your unmarried dependent children who are over age 19 but less than age 25 are eligible if they receive more than half of their support from you, and are **full-time** students at an accredited secondary school, preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. They continue to be eligible through the month in which they graduate. For children other than your natural children, legally adopted children or stepchildren, supported by you as described in Paragraph 2 above, coverage must have commenced before the child reached age 19.*

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

The Plan requires that proof of full-time student status be submitted at the beginning of each school year. This requirement applies to all full-time students who are over age 19 but less than age 25. The Plan will accept ONLY an Affidavit of Student Status for Dependent Form as proof. Copies of the Affidavit of Student Status for Dependent Form will be mailed to all enrollees who have dependents above the age of 19 at the beginning of each school year. Should you need a copy of the Affidavit of Student Status for Dependent Form, please contact the Third Party Administrator.

Medical Leave for Students Over 19: If your child is granted a medical leave by the school, health coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. You must be able to provide written documentation, including medical records, from the school and/or the physician if requested by the Third Party Administrator.

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

4. *Certain students completing graduation requirements:* Your unmarried dependent children who are over age 19 but less than age 25 who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:
 - A. Otherwise qualify, **AND**
 - B. Have been a full-time student in the term immediately preceding the semester or trimester which course requirements will be completed, **AND**
 - C. Be able to provide the East End Health Plan with a statement from their school or college administrator which verifies the student's status. They continue to be eligible through the end of the month in which they graduate. Coverage will not be extended beyond this semester unless full-time student status is resumed.

Effective January 1, 2003, an unmarried dependent student, 19 years of age or older but under 25, who graduates from an accredited secondary or preparatory school, college or other educational institution, may continue coverage for up to three months following the end of the month in which they graduate. Verification of the dependent student's graduation must be provided for this extension of coverage.

For dependents who leave school (cease to be full time students) but do not graduate, coverage ends the last day of the month in which the dependent last attended school.

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

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

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

6. *Domestic Partners: **Should your district elect to offer enrollment to domestic partners,*** they would be eligible if a Domestic Partnership Declaration Form, including all necessary proof, is submitted to the enrolling district. To be eligible, the following criteria must be met:

- a. The partners are, and have been, in a mutually exclusive affectionate, intimate relationship of mutual support, caring, and commitment with each other for the last twelve (12) months from the date of execution of this declaration.
- b. The partners share joint responsibility for the household.
- c. Neither partner is married or legally separated from anyone else.
- d. The partners are each at least eighteen (18) years of age and mentally competent to consent to this declaration.
- e. The partners are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
- f. The partners have resided together in the same residence for at least the last twelve months and intend to do so indefinitely. (Proof of 12 months residency is required to be submitted.)
- g. At least four of the following are true (check those which apply) (Proof of at least two (four) of the following is required to be submitted along with this Form.):
 - § an executed domestic partnership agreement in a jurisdiction which authorizes such agreements;
 - § the employee has named his or her domestic partner as a beneficiary under his or her will, or the domestic partner has named the employee as a beneficiary under his or her will;
 - § the employee has granted his or her domestic partner powers under a durable power of attorney or the domestic partner has granted the employee powers under a durable power of attorney;
 - § the employee has named his or her domestic partner as a beneficiary on his or her life insurance policy, or the domestic partner has named the employee as a beneficiary on his or her life insurance policy;
 - § the partners have each designated each other as healthcare surrogates on a health care proxy statement;
 - § the partners have a joint bank account, or they are cosigners of a lease or deed; or have a joint loan.

The dependent children of the partners are eligible for coverage when they are:

1. Unmarried;
2. Primarily dependent on the employee (the employee must provide more than 50% of the child's support) for support;
3. Permanently residing in the employee's household;
4. Meet the age/school and any other applicable requirements of the plan for benefits; and
5. May be claimed by the employee and/or domestic partner as a dependent as defined in IRC Section 152.

Domestic Partners agree to notify the enrolling school district if there is any change in their status as domestic partners as attested to on the Domestic Partnership Declaration which would make the non-employee partner and/or any of his/her dependent children ineligible for the East End Health Plan. (for example, due to the death of partner, a change in joint - residence, termination of the relationship, etc.)

One, or both of the partners must notify the enrolling school district within fourteen (14) days of such change in their status as domestic partners by filing a Declaration of Termination of Domestic Partnership (Declaration of Termination). The Declaration of Termination shall be on a form provided by the enrolling school district and shall affirm the domestic partner status terminated. The health insurance coverage will be terminated as of the end of the month of the date of receipt of the Declaration of Termination of the domestic partner status. A copy of the Declaration of Termination must be mailed to the other party within seven days of the filing of the Declaration of Termination.

Another Declaration of Domestic Partnership Form cannot be filed until two years after the effective date of the Termination of Domestic Partnership Form.

If you have any questions concerning eligibility, please contact the District's Health Plan Coordinator.

ENROLLMENT

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

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

To enroll for coverage, contact the District's Health Plan Coordinator.

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

WHEN COVERAGE BEGINS:

The District establishes the date on which an employee becomes eligible for coverage. This is the First Date of Eligibility. It may be as early as the first day of employment or up to six months after employment. You should consult with the District's Health Plan Coordinator for information that is specific to your District.

There may be a waiting period between your First Date of Eligibility and the date on which your coverage goes into effect.

The actual effective date is determined by **when you apply** for coverage. If you apply:

- On or before the First Date of Eligibility*, coverage begins on that date.
- Within one month after the First Date of Eligibility*, coverage begins on the first day of the month following your application.
- More than one month after the First Date of Eligibility*, coverage begins on the first day of the third month following your application.

No Coverage During Waiting Period: Medical expenses incurred or services rendered during your waiting period will **NOT** be covered. If possible, be sure to keep any other insurance you may have to cover medical or hospitalization expenses until your East End Health Plan coverage becomes effective.

HOW TO CANCEL ENROLLMENT:

To cancel your enrollment in the East End Health Plan or to cancel coverage for a dependent, see the District's Health Plan Coordinator to complete the necessary form.

COVERAGE: INDIVIDUAL OR FAMILY

Two types of coverage are available to you under East End Health Plan:

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

FAMILY COVERAGE provides benefits for you and your eligible dependents. To enroll yourself and your dependents in Family coverage, you must provide each person's date of birth and other information to East End Health Plan through the District's Health Plan Coordinator.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE:

If you qualify for a change from Individual to Family coverage and you want Family coverage, contact the District's Health Plan Coordinator.

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

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

- You acquire a new dependent (for example, you marry or have or adopt a child), or,
- Your spouse's other health insurance coverage ends. Written proof must be submitted to your District's Health Plan Coordinator.

Your new coverage begins according to when you apply:

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

Considered late if previously eligible: If you change to Family coverage in order to include your spouse or dependents who were **previously eligible** but unenrolled, their coverage will begin on the first day of the third month following the month in which you apply.

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

Exception for new dependent: However, an exception is made if you acquire a new dependent during the late enrollment waiting period after you apply for a change to Family coverage. (For example, if your child is born during the waiting period, the child will be eligible for benefits under your Family coverage beginning with the date of the child's birth.)

This exception coverage is not automatic. You must contact the District's Health Plan Coordinator for this benefit.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE:

You need to change to Individual coverage when you no longer have **any** eligible dependents.

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

Contact the District's Health Plan Coordinator for information about when your dependent's coverage ends if you change from Family to Individual coverage.

WAIVER OF PREMIUM

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

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

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

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

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

- You return to the payroll.
- You are no longer on a Preferred List.
- You are no longer disabled.
- You are no longer a District employee (and are not on a Preferred List)
- You vest your health coverage rights
- You retire
- You die

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

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

The Third Party Administrator will notify the District whether or not your waiver has been granted.

HOW CHANGES IN YOUR STATUS AFFECT COVERAGE

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

LEAVE WITHOUT PAY

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

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

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

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

Canceling Coverage While Off the Payroll: You may cancel your health coverage for the time you are on Leave Without Pay. Arrange for the cancellation with your District's Health Plan Coordinator **BEFORE** your last day of work. You will not be required to submit any premium payments. Your coverage will end on the last day of the month in which you request cancellation.

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

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

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

LAYOFF AND PREFERRED LIST:

If you are laid off and your name has been placed on a Department of Civil Service Preferred List, you may or may not be able to continue your health coverage for a limited period of time. Contact your District's Health Plan Coordinator for information on whether the District offers this optional program feature.

CONTINUING COVERAGE WHEN YOU RETIRE OR VEST

Most Districts permit enrollees who have met certain eligibility requirements to continue their coverage after retirement and contribute to the cost of such coverage. These requirements vary from District to District. **You should contact the District's Health Plan Coordinator for specific requirements of your school district.** The following information may be used as a general guideline.

ELIGIBILITY FOR RETIREE COVERAGE:

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

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

If you are a non-member and are at least 55 years of age and if last entry into service was **PRIOR TO** September 1, 1983 **OR** you are 62 years of age and if last entry occurred **ON OR AFTER** September 1, 1983, **AND**

- You must be enrolled in East End Health Plan as an enrollee or a dependent at the time of your retirement. For example, if you were on leave and canceled your coverage and then retired, you would not be eligible for health insurance in retirement.

However, some Districts that were covered by the Previous Health Program after March 1, 1972, may have elected not to provide coverage for retired employees.

Regardless of the date when the District began coverage in the previous health program (NYSHIP), your employer may require more than five years of service if you were hired after April 1, 1975. Furthermore, your employer may have elected not to provide continuation of coverage in retirement for employees hired on or after April 1, 1977.

Contact the District's Health Plan Coordinator to learn whether the District permits service with another public employer to count toward meeting your service requirement.

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

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

DISABILITY RETIREMENT:

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

In the case of a disability retirement resulting from a work-related illness or injury, the age requirement and the minimum service requirement are waived. Check with the District's Health Plan Coordinator for further information.

SUMMARY:

Before You Retire:

T Check the requirements for continuing your health benefits in retirement.

- Talk with the District's Health Plan Coordinator. Be especially sure to discuss the minimum service requirements.

- Carefully read the retirement information in this book.

T **If you are eligible to continue your health insurance benefits, ask your District's Health Plan Coordinator to:**

- Make sure the information on your enrollment record is up-to-date for you and your dependents: dates of birth, correct spelling of names, effective dates, address, etc.
- Tell you whether there will be any change in your health benefits.
- Tell you about other benefits to which you may be entitled.

T **Contact your Social Security Administration office three months before you or a dependent turns 65 to find out about enrolling in Medicare.**

T **Moving when you retire?**

- Before you retire:* Notify the District's Health Plan Coordinator of your address change.
- After you retire:* Notify the District's Health Plan Coordinator of any address change.

T **If you do not meet the requirements to continue coverage as a retiree, COBRA, the State Continuation of Coverage Law, or a direct-pay policy may allow you to continue health benefits.** You will receive this information from the District's Health Plan Coordinator. Read the chapters on Continuation of Coverage and Changing from East End Health Plan to Direct-Pay Contracts.

VESTING:

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

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

To continue coverage as a vestee, be sure to contact the District's Health Plan Coordinator before your last day of work to arrange for continuation.

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

In no case may the value of sick leave credits be applied toward health premium costs either while you are in vested status or after you become eligible to retire. (Your employer may allow you to apply all or part of the value of your sick leave credits toward your premium if you retire directly from active employment.)

Coverage Ends Permanently If You Do Not Continue As A Vestee:

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

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

COVERAGE FOR YOUR DEPENDENT SURVIVORS

Extended Benefits Period at No Cost:

The East End Health Plan protects your survivors if you should die. If you die while you are enrolled in East End Health Plan as a District employee, vestee, or retiree, your enrolled spouse who remains unmarried and enrolled dependent children will continue to receive coverage without charge for an extended benefit period of two months after the last month for which payment has been made. However, in no case will extended benefits continue more than three months following the month in which the enrollee dies.

If you die while you are enrolled in East End Health Plan through the State Continuation of Coverage Law or COBRA, your enrolled dependents will be eligible for continuation of coverage or change to a direct-pay contract.

Coverage After the Extended Benefits Period Ends:

Your spouse who remains unmarried and eligible dependent children will be allowed to continue their coverage under East End Health Plan after the extended benefits period ends, if you have completed 10 or more years of service.

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

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

For information on the cost of dependent survivor coverage, contact your District's Health Plan Coordinator.

Coverage for Your Eligible Dependents If Your Spouse Loses Eligibility Or Dies:

If your surviving spouse dies, your other eligible dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. If they no longer meet these requirements, they may be eligible to enroll through COBRA or change to a direct-pay contract.

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

If Your Family is Not Eligible For Dependent Survivor Coverage:

If your spouse and dependents are not eligible for survivor coverage under the East End Health Plan, they may be eligible to continue their coverage in East End Health Plan for a limited time under COBRA, or they may be eligible to convert to direct payment contracts. See your District's Health Plan Coordinator for further information.

CONTINUATION OF COVERAGE

This section summarizes your rights and obligations with regard to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (commonly known as "COBRA") and the New York State Continuation of Coverage Law. Your District's Health Plan Coordinator can provide you with the details of your rights to continue coverage. You must pay the full cost of coverage under either program.

Continuation of Coverage under COBRA

In the event that a covered person is no longer covered under the Plan, the covered person will have the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates, if coverage terminates for one of the reasons specified below. Your district's Health Plan Coordinator will provide notice of the right to continue coverage, once notice has been received that an event triggering that right has occurred.

A covered person who is an employee of a participating school district has the right to choose continuation coverage if coverage under the Plan terminates because of a reduction in hours of employment or because employment has terminated (for reasons other than gross misconduct on the employee's part).

A covered spouse of an employee of a participating school district has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following events:

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

A covered dependent child of an employee of a participating school district (*A dependent child includes a newborn child, an adopted child, and a child placed with the covered employee for adoption, during the COBRA coverage period. The COBRA coverage period ends at the same time as the other family members.*) has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following events:

1. the death of the parent employed by the participating school district;
2. the termination of employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment with the participating school district;
3. the divorce or legal separation of the dependent child's parents;
4. the entitlement to Medicare of the parent employed by the participating school district; or
5. the dependent child's ineligibility for coverage as a "dependent child" under the Plan.

Coverage may be continued for 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage. Coverage may be continued for 18 months in the event of termination or reduction in hours of employment.

The 18-month coverage period may be extended to 29 months for covered family members, if: (i) any covered family member (employee, spouse, or dependent child) is determined under Title II or Title XVI of the Social Security Act to have been disabled on or within 60 days of the date of termination or reduction in hours of the covered employee's employment; and (ii) the covered employee or a qualified beneficiary notifies the employee's participating school district within

60 days after the determination and before the end of the 18-month coverage period. Any coverage extended after the initial 18 months because of a disability determination may be charged to the covered person(s) at 150% of the group rate (even if coverage is ultimately continued for a total of 36 months, pursuant to the paragraph below), so long as the disabled person is covered during the extension. If it is later determined that the covered family member whose disability resulted in the extended coverage is no longer totally disabled, the covered employee or a qualified beneficiary must notify the employee's participating school district within 30 days of the determination.

If a covered spouse or dependent child continues coverage upon a termination or reduction in hours of employment, continuation coverage may be extended to 36 months if another event (death, divorce or legal separation, Medicare entitlement, or ineligibility for dependent coverage) occurs during the initial 18-month period. If one of these events occurs, the covered employee or another qualified beneficiary should notify the employee's participating school district right away. Continuation coverage will not last beyond 36 months from the date of the first event that made the covered person eligible to continue coverage. However, special rules may apply if Medicare entitlement is involved.

It is the responsibility of the covered person to notify the employee's participating school district within 60 days of the date of a divorce, legal separation, or a child losing dependent status under the Plan.

Continuation coverage may be cut short for the following reasons:

1. The employee's participating school district no longer provides group health benefits coverage to any of its employees;
2. The covered person fails to make timely payment of any premium due;
3. After electing continuation coverage, the covered person becomes covered under another group health benefits plan that either: (i) does not contain any exclusion or limitation; or (ii) contains an exclusion or limitation that does not apply to the covered person or has been satisfied in accordance with federal law;
4. After electing continuation coverage, the covered person becomes entitled to Medicare; or
5. Continuation coverage has been extended for up to 29 months due to a covered family member's disability, and there has been a final determination that the family member is no longer totally disabled.

To continue coverage, the covered person must submit a written election form to the participating school district within 60 days of the later of: (i) the date on which coverage terminates due to one of the events specified above; or (ii) the date additional notice is given of the right to continue coverage under the Plan. If an election form is not returned by or on behalf of a covered person within that 60-day period, it will be assumed that s/he does not wish to continue coverage under the Plan.

If an election is made to continue coverage, a covered person will be required to pay the premium for the coverage. Except with respect to continuation coverage extended for up to 29 months for a disabled person and any other covered family members whose coverage is extended with the disabled person's (or up to 36 months in the event that a second qualifying event occurs with respect to a qualified beneficiary whose coverage is extended due to disability), the premium payment will not exceed 102% of the group rate for the benefits, which includes an administration fee. If desired, premiums may be paid on a monthly basis. The covered person will be required to pay the first premium payment in advance, along with any retroactive premium payments owed from the date of termination of coverage, within 45 days after submitting the written election form.

At the end of the COBRA continuation coverage period, a covered person may enroll in an individual conversion health benefits contract, as described elsewhere in the Plan.

Continuation of Coverage under New York State Law

If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law. Contact the participating school district to find out if you are entitled to temporary continuation of coverage under COBRA or under New York law.

Under New York law, if a covered employee loses coverage because of termination of employment or membership in the class or classes eligible for coverage, the employee may continue coverage for him/herself and eligible dependents, subject to the following.

1. The covered person is not entitled to Medicare; and is not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions.
2. The covered person must request continued coverage within 60 days after the later of: the date of termination; or the date s/he is given notice of continuation by the participating school district. If the covered person wishes to continue coverage for up to 29 months due to a Social Security disability (see 4.d. below), s/he must notify the participating school district within 60 days after a determination and before the end of the that s/he was disabled under the Social Security Act at the time of termination of employment or membership or within the first 60 days of continuation coverage.

3. The covered person must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date the covered person is given notice of continuation by the participating school district. The premium cannot exceed 102% of the group rate.
4. Coverage will terminate at the earliest of the following:
 - a. the date 18 months after the covered person's coverage would have terminated because of termination of employment or membership;
 - b. The date to which premiums are paid, if the covered person fails to make a timely payment;
 - c. If the covered person is an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; ineligibility for dependent child status under the Plan;
 - d. The date 29 months after coverage would have otherwise terminated because of termination of employment or membership, if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in a. above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
 - e. The date the participating school district no longer provides coverage to any of its employees or members.

Continued Benefits after Termination for Total Disability under New York State Law

When a covered person is totally disabled, he or she may continue benefits for covered services to treat the total disability, if one of the following applies.

1. When coverage under the Plan ends because (i) the covered person is no longer actively employed; (ii) the covered person is no longer eligible for coverage under the Plan; or (iii) the Plan terminates; coverage will be provided under the Plan during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay and/or surgery must be for treatment of the injury, illness, or pregnancy causing the total disability.

2. When coverage under the Plan ends because the covered person is no longer actively employed, benefits will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, illness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

The continued benefits will terminate when:

1. the covered person has used all the Plan benefits available;
2. the Plan Administrator determines that the covered person is no longer totally disabled;
3. the covered person reaches the lifetime maximum amount payable under the Plan; or
4. benefits are continued under (1) above, and the covered person reaches the end of the 12-month period from the date coverage under this Plan ends.

The Plan will never pay more than the payments that would have been available, had a covered person remained covered under the Plan.

CHANGING FROM EAST END HEALTH PLAN TO DIRECT-PAY CONTRACTS

Under certain conditions, East End Health Plan enrollees and their dependents are entitled to direct-pay contracts. After your East End Health Plan coverage ends, or after your continuation coverage in East End Health Plan under the New York State Continuation of Coverage Law or COBRA ends, you may change to direct-pay contracts from United Healthcare. **There is no direct payment right for the Vision Care Program.**

COORDINATING YOUR EAST END HEALTH PLAN BENEFITS WITH MEDICARE

MEDICARE: A FEDERAL PROGRAM:

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

Medicare has two parts: **Part A** (hospital insurance) which can help pay for in-patient hospital care, in-patient care in a skilled nursing facility, home health care, and hospice care; and **Part B (medical insurance)** which can help pay for medically necessary physicians' services, out-patient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

PRIMARY COVERAGE:

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

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

WHEN EAST END HEALTH PLAN PAYS FIRST:

East End Health Plan will automatically provide primary coverage for an active employee, regardless of age, and for the employee’s enrolled dependents. For those who are eligible for Medicare due to permanent kidney failure, East End Health Plan is primary for generally the first 30 months of treatment, then Medicare becomes primary.

East End Health Plan also will automatically provide primary coverage for eligible retired employees, and their spouses, and other enrolled eligible dependents who are under age 65 and not disabled.

Active employees and their enrolled dependents who are eligible for Medicare because of permanent kidney failure or disability should provide a copy of their Medicare card to the District’s Health Plan Coordinator.

WHEN MEDICARE PAYS FIRST:

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

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

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

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

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

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

ENROLLING IN MEDICARE:

As An ACTIVE Employee Age 65 Or Over:

Since East End Health Plan automatically provides primary coverage for you and your enrolled dependents, you may delay enrollment in Medicare Parts A and B until you retire without penalty. Or, you may enroll at 65, but delay activating your benefits until you retire and need the coverage.

When you enroll in Medicare, you may elect it as your primary group insurer by notifying the District’s Health Plan Coordinator in writing. **However, if you do choose Medicare as your primary coverage while you are still an active employee, East End Health Plan coverage for you and your enrolled eligible dependents will end, and your benefits will be drastically reduced.**

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

When You Retire Before Age 65:

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

When You Retire At Age 65:

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

How to Enroll:

You can sign up for Medicare by telephone and mail. Contact your local Social Security Office at **1-800-772-1213**. Ask for a Teleclaim appointment.

NOTE: Not enrolling could reduce your benefits drastically.

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

East End Health Plan Supplements Medicare:

After you retire, East End Health Plan will not provide any benefits that could be obtained from Medicare, but it will provide benefits to supplement those available from Medicare. You will continue to have the same benefits available under East End Health Plan as you had before you were eligible for Medicare, with one exception. The exception is that, once you are eligible for Medicare, with one exception. The exception is that, once you are eligible to receive any Medicare benefits, you are no longer eligible to receive benefits for Skilled Nursing Facility charges under East End Health Plan. You will have coverage for Skilled Nursing charges to the extent that Medicare covers these charges.

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

Medicare Premium Reimbursement:

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

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

Since reimbursement practices vary from district to district, you should contact your District's Health Plan Coordinator for information. Extra charges imposed by Social Security as penalties for late enrollment in Medicare are not reimbursable under East End Health Plan.

FILING CLAIMS UNDER MEDICARE AND THE EAST END HEALTH PLAN:

Expenses covered by Medicare must be submitted to Medicare before being submitted to the East End Health Plan when Medicare is the primary carrier.

In-Patient Hospital Expenses:

When you are admitted to a hospital, you must show your East End Health Plan Hospitalization and Medicare cards to the admitting office. You should not be billed for any charges covered under these programs.

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

If you exhaust the 365-day hospitalization benefit and your Medicare 60-day reserve, the Major Medical portion of the East End Health Plan will provide benefits for additional covered in-patient charges.

Out-Patient Hospital Expenses:

Necessary out-patient hospital expenses incurred for surgery, emergency illnesses, emergency accident cases, diagnostic X-rays and laboratory tests which are not covered by Medicare will be covered by the Hospitalization portion of the East End Health Plan subject to a co-payment with certain limitations described in the Hospitalization Section. Out-patient charges should be submitted by the hospital with Medicare Explanation of Benefits form (EOB), if applicable, and an itemized bill to the Third Party Administrator.

Preferred Provider Program and Major Medical Coverage:

Whether you receive services from an East End Health Plan Preferred Provider or from a provider who does not participate in the East End Health Plan, you should discuss payment before you receive services. If your provider does not accept Medicare assignment, you may be required to pay the Medicare reimbursable amount at the time of service.

If the provider participates in the East End Health Plan, you are responsible for paying a co-payment to the provider. An example would be the co-payment for a physician's office visit. But the amount you owe may be less, depending on how much Medicare reimburses.

Steps for You to Take:

The following four examples describe the steps you should take in various situations when Medicare is your primary coverage. The examples assume that all expenses are covered expenses under both Medicare and the East End Health Plan.

Example 1: The provider accepts Medicare assignment. The provider participates in the East End Health Plan.

You are responsible for paying any co-payment directly to the provider. You will not have to file any claims; the provider will do the paperwork. Medicare and East End Health Plan benefits are paid directly to the provider.

Example 2: The provider accepts Medicare assignment. The provider does NOT participate in the East End Health Plan.

Step 1. Medicare benefits are paid directly to the provider. When the Medicare claim is processed, you will receive a Medicare Explanation of Benefits (EOB) statement.

Step 2. You must file an East End Health Plan claim. Send your Medicare EOB statement, the provider's bill, and a signed claim form to the Third Party Administrator. The Third Party Administrator will send you a reimbursement check for any benefits due under the East End Health Plan.

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

Example 3: **The provider does NOT accept Medicare assignment. The provider participates in the East End Health Plan.**

Step 1. You are responsible for paying any co-payment directly to the provider.

Step 2. The provider will file a claim for you with Medicare. When the Medicare claim is processed, you will receive a reimbursement check and a Medicare EOB statement.

Step 3. You then must file a claim form with the Third Party Administrator enclosing your receipt from the provider and the Medicare EOB statement. The Third Party Administrator will send you a check for any reimbursement due you under the East End Health Plan.

CLAIMS DEADLINE:

East End Health Plan claims must be submitted no later than 90 days after the end of the calendar year or 90 days after you receive your Medicare EOB, whichever is later.

When You Reside Outside the United States:

Medicare does not cover medical expenses incurred outside the United States. East End Health Plan pays as primary insurer, whether or not you are enrolled in Medicare. Your former employer discontinues your Part B reimbursement. You must notify your former employer (in writing) if you will be residing outside the United States.

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

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

Re-Employment: If you return to work with an employer who participates in East End Health Plan and meet the eligibility requirements for coverage, East End Health Plan will again provide primary coverage for you and your enrolled dependents. At the time of your re-employment, contact your District's Health Plan Coordinator to arrange to notify the Third Party Administrator and to find out your effective date for East End Health Plan coverage.

KEEPING YOUR COVERAGE UP TO DATE

Changes in Your Enrollment Status:

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

T Your Family Coverage:

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

T Your Status Changes

- You are going to retire from your District
- You are affected by a layoff
- You are going on Leave Without Pay
- You want to continue your health coverage while in vested status
- You have questions about COBRA continuation
- You become disabled and want to apply for a Waiver of Premium
- You want to cancel your health coverage to obtain dependent status under your

spouse's East End Health Plan coverage

T You Have Questions About East End Health Plan

- You have questions concerning your family's eligibility for health coverage
- You have questions about changing your type of coverage (Family/Individual)
- Your Employee Benefit Identification Cards are lost or damaged
- You or a dependent does not receive your Employee Benefit Identification Card
- You want to know how to coordinate your East End Health Plan benefits with Medicare
- You want to cancel your coverage
- Your home address changes
- You would like a Preferred Provider Directory

EAST END HEALTH PLAN

PART II

MANAGED CARE PROGRAM

PART II - MANAGED CARE PROGRAM

The East End Health Plan includes a Managed Care Program. All of the in-patient benefits provided under the East End Health Plan are subject to the provisions of the Managed Care Program. In addition, all of the benefits for in-patient admissions to private proprietary hospitals for treatment of mental and nervous conditions and alcoholism, and to approved facilities other than hospitals for treatment of alcoholism and/or substance abuse are subject to the Managed Care Program. Please note that out-patient treatment includes procedures in a physician's office.

Managed Care requirements apply to all enrollees with coverage under the East End Health Plan and to their enrolled spouse and other enrolled dependents whose coverage is under the East End Health Plan. The East End Health Plan is **primary** when it is responsible for paying for health benefits first, before any other group plan or HMO is liable for payment.

In most cases, it is no longer necessary to pre-certify when your Health Plan is the secondary carrier. If your primary carrier has pre-certified the services and has paid the claim, the Third Party Administrator will authorize payment in accordance with the secondary plan's provisions. **PLEASE NOTE: If your primary carrier applied a penalty due to lack of pre-certification, the Third Party Administrator will also apply a penalty as the secondary carrier.**

If your primary carrier deems that the services you are pre-certifying are not medically necessary, you must pre-certify through the Third Party Administrator to establish medical necessity. **Pre-certifying does not imply the service is covered.**

Managed Care services apply if you live or seek treatment anywhere in the United States including Alaska and Hawaii. This summary explains the program and your responsibilities.

The East End Health Plan is designed to make sure that the hospital setting is medically necessary and that certain health care services you and your families receive are medically necessary and appropriate.

The Managed Care Program is administered by the Third Party Administrator. It provides:

- Pre-Admission Certification
- Concurrent Review
- Discharge Planning
- Medical Case Management
- Second Surgical Opinion Program
- Mastectomy Second Medical Opinion Program
- Managed Physical Medicine Program
- Out-Patient Mental Health, Alcoholism and Substance Abuse Program

You must call **the Third Party Administrator** within 30 days for any elective (scheduled)

admission that will include an overnight stay in a hospital. You must call before the admission. The Plan urges you to call as soon as your physician determines that you or one of your enrolled dependents should be admitted to a hospital or approved facility as an inpatient for an elective admission. Call as soon as possible; don't delay making the call.

Hospital in-patient benefits available under the terms of this Plan shall include coverage for a mother and her newborn for at least 48 hours after childbirth for any delivery other than a Caesarean Section and for at least 96 hours following a Caesarean Section.

YOU ARE RESPONSIBLE FOR THE CALL. However, a member of your family or household, your physician, or a member of your physician's staff may also place the call. In the case of an emergency or urgent admission, the hospital admitting office may place the call for you. Where these articles refer to "you" making the call, keep in mind that the other people listed may also call.

MANAGED CARE'S EIGHT PARTS:

PRE-ADMISSION CERTIFICATION:

When you call within 30 days for pre-admission certification, a Case Manager from the Third Party Administrator will call your physician's office. If the information indicates that the hospital setting is medically necessary according to nationally accepted standards, the admission will be pre-certified. Pre-certification assures that the East End Health Plan benefits will be available to you to the full extent for covered services.

If the medical necessity of the hospital setting is not confirmed, a board-certified, actively practicing Physician Advisors representing the Third Party Administrator will discuss the hospitalization with your physician. If the Physician Advisor determines that the admission is not medically necessary and your physician does not agree to an alternate setting, a second Physician Advisor will review the proposed hospitalization.

The second Physician Advisor, from the same or related specialty as your physician, will discuss the hospitalization and various alternatives with your physician. If the Physician Advisor does not agree that the admission is medically necessary, your admission will not be pre-certified.

Within 48 hours after the Third Party Administrator's Case Management Department reaches your physician, the Third Party Administrator's Case Management Department will send written notification of their decision to you, to the hospital and to your physician.

If, as a result of this review, hospitalization for you or your enrolled dependent is not pre-certified, you may choose to go ahead with the hospitalization. If you do, you will be required to pay:

- T \$200 of the total billed hospital charges **AND**
- T \$100 of the charges for each day it is determined that your hospitalization is not medically necessary.

If you do not follow the Pre-Admission Certification Requirements:

- If you did not call the Third Party Administrator's Case Management Department for pre-admission certification of an elective (scheduled) inpatient admission, **OR**
- If you did not call the Third Party Administrator's Case Management Department within **48** hours of an emergency or urgent admission, **OR**
- If you followed the procedures for emergency or urgent admissions when you should have followed the pre-admission certification procedures for an elective (scheduled) admission, or an admission for the birth of a child, you will be required to pay:
 - T \$200 of the total billed hospital charges **AND**
 - T \$100 of the charges for each day it is determined that your hospitalization is not medically necessary.

Also, if it is determined upon review of your in-patient claim that your in-patient admission was not medically necessary, a full or partial retro-active denial of in-patient benefits could result.

CONCURRENT REVIEW:

If you or your spouse or child is hospitalized, the Third Party Administrator's Case Management Department will monitor progress through the **Concurrent Review Program**. Medical review specialists will work with your physician to monitor treatment needs. The goal of Concurrent Review is to encourage the appropriate use of in-patient care. If the Third Party Administrator's Case Management Department determines that in-patient care is no longer medically necessary, you, your physician and facility will be notified not later than the day on which the East End Health Plan in-patient benefits cease.

DISCHARGE PLANNING:

If you or your spouse or child needs special services after hospitalization, the Third Party Administrator's Discharge Planning Unit nurses will help, The Third Party Administrator's nurse will review the patient's recovery to determine what services are medically necessary (such as a visiting nurse's services, skilled nursing facilities, physical therapy and hospice).

Using your physician's treatment plan, the Third Party Administrator's nurse will make the necessary arrangements and coordinate these services for you and your family. These services will be covered in accordance with the East End Health Plan provisions.

MEDICAL CASE MANAGEMENT:

Some serious conditions, such as severe burns, head injuries or neonatal (newborn) complications, may require extended care. If you or a member of your family requires extended care, you will be faced with many decisions about treatment plans and facilities. The Third Party Administrator's Case Management can provide information to help you make these decisions.

Pre-Admission Certification and Concurrent Review help the Third Party Administrator determine if Medical Case Management would help you and your family, nurse-specialist from the Third Party Administrator will contact you. Participation is voluntary and you can terminate your participation at any time.

If you accept this service, the nurse from the Third Party Administrator will begin working with your physician to coordinate your care and services that are covered under the East End Health Plan.

After discussions with you, your family and your physician, the nurse from the Third Party Administrator may suggest an alternate treatment plan or facility, such as a speciality hospital or home care services. The nurse from the Third Party Administrator and your physician will help you review these suggestions. Once you and your physician agree to a plan, the Third Party Administrator's staff will help implement it.

Through your discussions with the Third Party Administrator's Case Management Department, you and your medical specialists will be aware of your options. By talking with you and your family about the range of medical treatment and facilities available, Medical Case Management can help you make the choices that are best for you.

SECOND SURGICAL OPINION PROGRAM

If you or an enrolled dependent is scheduled for a surgical procedure, you may call to request a second opinion before undergoing elective, non-emergency surgery. The Third Party Administrator's Case Management Department will provide you with the names of up to three physicians in your geographic area whose specialty is comparable to your physician's. The Third Party Administrator's Case Management will arrange for the second opinion. There is no cost to you. The second opinion will provide you and your physician with additional information and possible alternatives to the recommended procedure.

After the second opinion, it is up to you to decide whether to go ahead with the procedure. If you decide to go ahead, your benefits will be paid according to the East End Health Plan guidelines for the procedure. However, if the specialist from whom you obtained the second opinion performs the procedure, the second opinion will not be considered a covered expense under the East End Health Plan; you will be responsible for the cost of the evaluation.

If you will be admitted to the hospital for the procedure, be sure to verify with the nurse from the Third Party Administrator that your in-patient admission has been pre-certified.

Once you have obtained the second surgical opinion, **you have up to six months to schedule the procedure.** If you postpone the procedure longer than six months, or if your physician decides on an alternative to the surgical procedure and then, at a later date, decides the surgical procedure needs to be done, you must call the Third Party Administrator's Case Management Department again to initiate another review.

Remember, second surgical opinions are available if you or an enrolled dependent lives or seeks treatment anywhere in the United States. Once the evaluation is completed, it is up to you whether to have the surgery.

MASTECTOMY SECOND MEDICAL OPINION PROGRAM

Mastectomy coverage for a second medical opinion will be covered by an appropriate specialist where there is a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer.

MANAGED PHYSICAL MEDICINE PROGRAM

Benefits for Physical Medicine are subject to a review process through the Case Management Department at the Third Party Administrator. To obtain pre-certification of these services, your chiropractor or therapist must call the Third Party Administrator's Case Manager prior to rendering services. The pre-certification process applies for these services regardless of whether your Health Plan is primary or secondary.

If the information obtained indicates that, based on reasonable expectations, the continuation of treatment would result in significant improvement of the patient's condition, the case will be certified and a written authorization will be forwarded for the approved number of visits.

Continued repetitive treatment without an achievable and clearly -defined goal is considered maintenance therapy and is not covered. The extent of coverage is determined by the Plan, based on an on-going review on a case-by-case basis. This certification process does not guarantee coverage. If the care you received was not pre-certified and/or not necessary as indicated above, you will be responsible for the full cost of care.

OUT-PATIENT MENTAL HEALTH, ALCOHOLISM AND SUBSTANCE ABUSE PROGRAM

Benefits for mental health services, alcoholism and substance abuse are subject to a review process which is followed by both you and your physician. Review the benefits booklet before you obtain services. If your in-patient or out-patient treatment is found not medically necessary, you will not receive any benefits and you will be responsible for the full cost of care. To obtain pre-certification for out-patient mental health care, all therapists must call the Third Party Administrator's Case Managers before the sixth visit. **You must still pre-certify these services, regardless of whether your Health Plan is primary or secondary.** Also, before you seek substance abuse care, including treatment for alcoholism, your therapist must contact the Third Party Administrator's Case Management. If the information indicates that the care is necessary according to medically accepted standards, the care will be certified and a written authorization will be forwarded for the approved number of visits. This certification does NOT guarantee coverage. The Plan carriers will determine eligibility and benefits as part of the claims review process.

Call the Third Party Administrator if you have any questions about benefits. Confidentiality of all information provided is assured.

Medical records and information are held in the strictest confidence at all times.

HOW TO REACH the Third Party Administrator's CASE MANAGEMENT DEPARTMENT

Calling the Third Party Administrator's Case Management Department is easy and toll-free. Call the toll free number listed in the contact section at the beginning of the Plan Document. The Third Party's Administrator's business hours are **9:00 a.m. to 5:00 p.m. (E.S.T.)** Monday through Friday, except holidays. At other times, an answering machine will take your information and a nurse from the Third Party Administrator will return your call. Please leave your name, your area code and telephone number and the best time to reach you during the following business day.

Be ready to supply the following information to the nurse from the Third Party Administrator:

- T Enrollee Social Security Number (from Employee Benefit Card)
- T Patient's address and phone number
- T Physician's name, address and phone number
- T Name of hospital
- T Anticipated date of admission or service

EAST END HEALTH PLAN

PART III

HOSPITALIZATION

&

RELATED EXPENSE COVERAGE

**PART III
HOSPITALIZATION & RELATED EXPENSE COVERAGE
IN-PATIENT HOSPITAL CARE**

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

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

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

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

IN-PATIENT SERVICES:

Number of Days of Care: The Plan will provide up to 365 benefit days of care for each spell of illness. The days of care may be for inpatient hospital care, maternity care in a birthing center, skilled nursing facility care, or home health care. There is a limit of 120 benefit days of care for a spell of illness for mental or nervous conditions and tuberculosis.

A spell of illness begins when:

- You are admitted to a hospital or birthing center; **OR**
- You are admitted to a skilled nursing facility; **OR**
- You receive home health care.

The spell of illness ends when, for a period of at least 90 days, you have **NOT**:

- Been a patient in a hospital or birthing center; **OR**
- Been a patient in a skilled nursing facility; **OR**
- Received home health care.

In-Patient Hospital Care: Each day of in-patient hospital care, or care in a birthing center, counts as one day of care toward the 365-benefit-day limit. There is a limit of 120 days of care during a spell of illness for care of mental and nervous conditions, and for only 120 days of care during a spell of illness for care of tuberculosis. The 120 days are not in addition to the 365 benefit days of care for a spell of illness. They are counted toward determining when you have reached the maximum 365 benefit days.

Skilled Nursing Facility Care: Each day of care in a skilled nursing facility counts as one-half benefit day of care. For example, 20 days in a skilled nursing facility count as 10 benefit days of care toward the 365-benefit-day limit.

Home Health Care: Each home care visit counts as one-third benefit day of care. For example, 30 home care visits count as 10 benefit days of care toward the 365-benefit-day limit.

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

PLEASE NOTE: Benefits in a skilled nursing facility are not provided if you are eligible to receive primary benefits from Medicare.

You are not eligible to receive hospitalization benefits if your Medicare benefits for skilled nursing facilities have been exhausted.

BED, BOARD AND GENERAL NURSING CARE:

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

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

OTHER HOSPITAL SERVICES:

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

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

MATERNITY CARE:

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

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

NEWBORN CHILDREN:

Benefits are available from birth.

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

OUT-PATIENT SERVICES

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

- 1. Emergency Services:** The Plan pays the medically necessary allowable amount for those covered services, supplies and facility related expenses that are provided by the hospital for emergency care given for an emergency condition. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

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

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

- 2. Minor Surgery:** Subject to a co-payment per visit. Benefits for follow up care at the hospital such as suture removal and check-up visits will be provided for only when billed inclusive of the initial visit.
- 3. Radiation Therapy.**
- 4. Laboratory Tests:** Benefits for the use of the in-network laboratory provider will be paid at 100% with no co-payment. Benefits for the use of an out-of-network laboratory provider will be subject to co-payment per visit. In addition, please note that since the Third Party Administrator does not have a contract with out-of-network providers, they may not accept assignment of the benefit resulting in the patient having to pay the cost of the laboratory services and then submitting a claim form to the Third Party Administrator for reimbursement. Laboratory tests will be paid for only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your physicians. You must be present at the out-patient department. Payment will not be made for physicians' charges for interpretation of X-rays or laboratory tests.

Diagnostic X-rays: Subject to a co-payment per visit. Diagnostic X-rays will be paid for only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your physicians. You must be present at the out-patient department. Payment will not be made for physicians' charges for interpretation of X-rays or laboratory tests.

5. **Pre-surgical Testing:** Subject to a co-payment per visit. The following conditions must be met:
- A. The tests are ordered by a physician as a preliminary step in your admission to a hospital as a registered bed patient for surgery; **AND**
 - B. They are necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; **AND**
 - C. You have a reservation for the hospital bed and for the operating room before the tests are given; **AND**
 - D. You are physically present at the hospital when the tests are given; **AND**
 - E. Surgery actually takes place within **14** days after the tests are given.
6. **Physical Therapy:** Benefits will be provided for physical therapy in an outpatient setting only when all the following conditions are met:
- A. The treatments are ordered by your physician; **AND**
 - B. The treatments are in connection with the same illness for which you had previously been hospitalized, or are related to in-patient or out-patient surgery.
 - C. The treatments must start within six months from your discharge from the hospital or within six months from the date surgery was performed.
 - D. No payment will be made for physical therapy given after 365 days from the date you were discharged from the hospital or the date of the surgery.

Please note that physical therapy benefits are available under the major medical provisions of the plan also. Please see Part IV of this document for details.

7. **Hemodialysis Treatment:** The treatments must be ordered by your physician.

8. **Chemotherapy:** The treatment must be ordered by your physician. However, payment will not be made for:

- A. Oral chemotherapy; **OR**
- B. Subcutaneous injection; **OR**
- C. Intramuscular injection

9. **Mammography Screening:** Subject to a co-payment. Mammography screening for occult breast cancer is covered as follows:

- A. Upon the recommendation of a physician, at any age for covered enrollees who have a prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
- B. A single baseline mammogram for covered enrollees 35 through 39 years of age;
- C. An annual mammogram for covered enrollees 40 years of age and older.

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

10. **Administration of Desferal for Treatment of Cooley’s Anemia:** Subject to a co-payment per visit. Benefits will be provided for out-patient visits when it is ordered by a doctor and performed at a hospital qualified to provide this service as determined by the Plan.

11. **Psychiatric Care in a Day or Night Care Center**

Out-patient visits will be provided for care of mental and nervous conditions in a day or night care center of an acute care general or public hospital. The following conditions must be met:

- A. The care must be in lieu of hospitalization; and
- B. The patient must remain in the day or night care center for at least three hours; and
- C. The program must be certified by the appropriate state agency, if the hospital is located in another state; or
- D. The program must be certified in New York State according to the State’s mental hygiene law.

HOME HEALTH CARE

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

Covered Services Include:

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

When home care is provided through a certified agency, and begins within 7 days following discharge from a hospital, these additional services are covered:

- Medical Social Worker Visits
- X-Ray and EKG Services
- Ambulance or Ambulette to the Hospital For Needed Care

Each home care visit counts as one-third benefit day of care. For example, 30 home care visits count as 10 benefit days of care toward the 365 benefit day limit.

CARE IN SKILLED NURSING FACILITIES

Full benefits are provided for covered hospital services received in a skilled nursing facility if the patient is referred by a physician for continuing treatment, and admission to the skilled nursing facility immediately follows a hospital confinement of at least 3 consecutive days.

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

REMINDER: Once you are eligible to receive **any** Medicare benefits, you are no longer eligible to receive benefits for Skilled Nursing Facility charges under East End Health Plan. You will have coverage for Skilled Nursing Facility charges to the extent that Medicare covers these charges.

MENTAL OR NERVOUS DISORDERS

Hospital benefits for mental or nervous disorders are provided for up to 120 days of in-patient care per spell of illness in:

- An acute care participating general hospital, **OR**
- An acute care general hospital located outside our operating area, **OR**
- A hospital in New York State located outside our operating area which fits the definition in Subdivision 10 of Article 1.03 of the Mental Hygiene Law.

ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT (Subject to the Mental Health, Alcoholism and Substance Abuse Program)

This benefit is subject to a co-payment per visit. Out-patient benefits for the diagnosis and treatment of alcoholism and/or substance abuse are available to each covered person and may be used in any combination for up to 60 visits per calendar year. Up to 20 of these visits may be used for family counseling, even if the patient's treatment has not yet begun. Family counseling is available to all persons covered under the patient's family contract. Benefits for family counseling are limited to one visit a day.

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

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

HOSPICE CARE

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

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

Typically, covered hospice and out-patient services include:

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

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

- Intermittent care by an RN, LPN or Home Health Aide
- Physical therapy
- Speech therapy
- Occupational therapy
- Respiratory therapy
- Social services
- Nutritional services
- Laboratory examinations, X-rays, 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 U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental nature)
- Medical care provided by the hospice physician
- Respite care
- Bereavement counseling for the member's family, before and until one year after the member's death.

WORLDWIDE PROTECTION

Hospitalization benefits are provided anywhere in the world.

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

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

If you are required to pay a bill for services provided under your contract, submit the itemized bill along with a claim form to the Third Party Administrator and you will be reimbursed.

EAST END HEALTH PLAN

PART IV

MAJOR MEDICAL EXPENSE BENEFITS

&

PREFERRED PROVIDER PROGRAM

PART IV

MAJOR MEDICAL EXPENSE BENEFITS & PREFERRED PROVIDER PROGRAM

MEANING OF TERMS USED

“This plan” means the medical expense provided under the East End Health Plan.

The word **“you”** as used in this Plan means you (the employee and/or retiree), and you (an eligible dependent member of the employee’s and/or retiree’s family). **“Employee*,” “dependent”** and **“family”** are defined in the “General Information” section of this booklet.

1. **“Provider”** means any physician, dentist, nurse, chiropractor, certified nurse-midwife, optometrist, physical therapist, speech therapist, podiatrist, psychologist, Visiting Nurse service, or facility legally licensed to perform a covered medical service; it also includes certified and registered social workers with at least six years of post-degree experience who have been qualified by the New York State Board for Social Work.
2. **“Preferred Providers”** are those eligible providers who have agreed to accept payment directly from the Plan, in accordance with the Schedule of Allowances, as payment-in-full for covered medical services under the Preferred Provider Program. Exceptions to payment-in-full under the Program are detailed in the sections on “Managed Care Program Services” and “Second Surgical Opinion Program”.
3. **“Schedule of Allowances”** means the Plan’s schedule, listing the amount it will pay to Preferred Providers for covered medical services.
4. **“A non-participating provider”** is one who has not entered into an agreement with the Third Party Administrator to accept payment in accordance with the Schedule of Allowances for covered medical expenses under this Plan. You are responsible for paying non-participating provider’s charges. To receive reimbursement for such charges, you must file a claim under the Major Medical portion of this Plan. The fees charged by a non-participating provider may exceed the amount reimbursed by the Plan. You may also assign your benefits to the non-participating providers (if they accept).
5. **“Hospital”** is defined as an institution which fully meets every one of the following tests:
 - It is primarily engaged in providing, on an in-patient basis, diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice; **AND**
 - It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses; **AND**

- It is not a skilled facility and it is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

“Approved facility” - means an institution which is licensed or recognized by the State of New York and approved by the Joint Commission on Accreditation of Hospitals.

“Physician” means a person legally licensed to practice medicine or osteopathy. **“Dentist”** means a person legally licensed to practice dentistry. **“Nurse”** means a registered professional nurse (R.N.)

6. **“Covered medical expenses”** under the Major Medical portion of this Plan means the Reasonable and Customary charges for covered medical services performed or supplies prescribed by a physician, except as otherwise provided, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service or supply is received by you. A more detailed description of covered expenses and exclusions is provided in the following pages.
7. **“Reasonable and Customary charge”** means the lowest of:
 - A. The actual charge for a service or supply, **OR**
 - B. The usual charge by the physician or other provider for the same or similar service or supply, **OR**
 - C. The usual charge of other physicians or other providers of similar training or experience in the same or similar geographic area for the same or similar service or supply.

The determination of the Reasonable and Customary charge for a service or supply is made by the Plan. You are responsible for any amount billed by a non-participating provider which exceeds the Reasonable and Customary charge, in addition to the annual deductible and co-insurance amounts.

8. **“Deductible”** means the amount you must pay for covered medical expenses each calendar year before benefits will be paid under the Major Medical expense portion of this Plan. There is no deductible for benefits paid through the Preferred Provider portion of this Plan.
9. **“Calendar year”** means the period beginning with January 1 and ending with December 31.
10. **“Co-insurance”** means the difference between the Reasonable and Customary charge and the covered percentage under the Major Medical expense portion of this Plan. You pay the co-insurance.
11. Under the Preferred Provider Program, the covered percentage is 100% of the Schedule of Allowances after the co-payment, except for durable equipment which is 10% of the purchased price. Under the Major Medical expense portion of this Plan, the covered

percentage for covered medical expenses is 80% of the Reasonable and Customary charge, **except:**

- A. As provided for out-patient psychiatric visits,
 - B. As provided under the Managed Care Program for certain procedures,
 - C. As provided for by the Managed Care Second Surgical Opinion Program; **AND**
 - D. The covered percentage becomes 100% of the Reasonable and Customary charge once the combined co-insurance amount for you (the employee and/or retiree) and your covered dependents exceeds \$900 in the calendar year. However, in calculating this \$900 co-insurance maximum, the annual deductible and any benefits paid for out-patient psychiatric visits are not included.
12. **“Out-patient”** means that covered medical expenses are incurred in a physician’s office, in the out-patient department of a hospital or approved facility, or in a surgical facility,
13. **“In-patient”** means during confinement for which a room and board charge is made by a hospital or approved facility.
14. The annual/lifetime maximum of the Major Medical portion of your medical expense benefits and applies to you (the employee) and each member of your family separately. Benefits paid through the Preferred Provider Program do not count toward the annual maximum.
- If \$1,000 or more of such benefits has been paid on your behalf under the Major Medical portion of this Plan, you may reinstate your full additional lifetime maximum. This can be done by furnishing, at your own expense, evidence of your good health acceptable to the Plan. Reinstatement of maximum benefits may be requested, and the required evidence submitted, at any time prior to the employee’s retirement.
15. A **“medical emergency”** is a life-threatening condition which requires immediate medical attention and treatment in order to avoid a serious impairment of a bodily function unless treated immediately.

SCHEDULE OF BENEFITS

NOTE: The dollar values maximum benefits, co-payments and deductibles as well as the co-insurance percentages are all identified in the Summary of Benefits Section at the beginning of the Plan Document. Certain benefits under the program for services such as well-baby care, annual physicals over age 50, and out-patient psychiatric benefits may have different co-insurance/schedule of benefits and/or not be subject to deductibles. Consult the entire booklet for details.

The medical portion of your East End Health Plan coverage is basically broken down into two parts. The following information will give you an overview of how these two parts work.

- 1.** Preferred Providers have agreed to accept a Schedule of Allowances for their services. This is the Preferred Provider Program of the Plan. When you use a Preferred Provider, charges for covered services are paid directly to the provider by the Plan in accordance with the Schedule of Allowances. All you pay the Preferred Provider for covered services is the co-pay per visit. The claim form is sent in by the provider, and you will periodically receive a summary Explanation of Benefits form which will tell you what benefits the Preferred Provider received. You may always request that an Explanation of Benefits form be sent to you directly for any service provided by contacting the Third Party Administrator.

Please take the time to review the EOB to ensure that the stated services were provided and to notify the Third Party Administrator of any errors you may find.

By using Preferred Providers, you help keep the cost of the Plan at a reasonable level, and your inconvenience is kept to a minimum.

- 2.** The other portion of this Plan is referred to as the Major Medical Expense Program. When you use a non-preferred provider, you are responsible for payment of the provider's charges, and must submit a claim for benefits due you. You share in the payment of charges. You are liable for an annual deductible and for a percentage of covered medical expenses in excess of the deductible. You may also assign the benefits under this program.

There are also special benefits provided under the "Managed Care Program," "Second Surgical Opinion Program" and "Out-Patient Psychiatric Services" segments of this Plan.

You should refer to the appropriate segments which follow explaining each of these areas in detail.

PREFERRED PROVIDER PROGRAM

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

There is no cost to you for services or supplies when they are covered under the Preferred Provider Program, except for the co-payment*. A Directory of all the Preferred Providers in your area will be given to you so that you may select the provider of your choice. At the time services are sought, patients should always ask their provider if he or she is a participant in the Third Party Administrator's Preferred Provider Network.

* **SERVICES NOT SUBJECT TO CO-PAYMENT:** Chronic care services for *chemotherapy, radiation therapy, hemodialysis*, and office visit charges by a Preferred Provider for *well-child care*.

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

- 1. Office and Home Visits:** You are covered for physicians' office visits and home visits by a physician for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-baby care. General medical care includes routine pediatrics and physical exams.
- 2. In-Hospital Physician's Visits:** You are covered for physician's visits while an in-patient in a hospital if such visits are not related to surgery. **Benefits for visits related to surgery are included in the scheduled amount for the surgery.**
- 3. Surgery:** You are covered for the services of a physician for surgery, including post-operative care, whether performed in or out of a hospital. ***In the same visit, if you have an office visit charge and an office surgery charge, only ONE CO-PAYMENT will apply.***
- 4. In-Hospital Anesthesia:** You are covered for anesthesia services if such services are performed in connection with in-hospital and ambulatory surgery, maternity care or shock therapy. **You are not covered if the anesthesia services are administered by your physician, by your physician's assistant or by a hospital employee.**
- 5. Maternity Care:** You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. Payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided.

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

nurse-midwife must be:

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

- 6. Specialist Consultations:** Your physician may refer you to a specialist for a consultation. During the consultation, the specialist will evaluate your medical condition and give you and your physician professional advice on how to proceed with your care. This specialist may or may not be a Preferred Provider. If you wish to use a specialist who is a Preferred Provider, you should refer to the list of providers in your area. When you use a non-preferred provider, benefits are payable under the Major Medical portion of this Plan.

You are covered for one out-of-hospital consultation in each specialty field per calendar year for each condition being treated. You are covered for an in-hospital consultation in each specialty field, per confinement, for each condition being treated.

You are **NOT** covered for consultations in the fields of pathology, roentgenology or anesthesiology.

- 7. Diagnostic Laboratory and X-Ray Examinations:** You are covered for diagnostic laboratory and x-ray procedures performed out of a hospital. You are also covered for the separate interpretation of x-rays by a radiologist if the radiologist bills separately. If both diagnostic laboratory and diagnostic radiology procedures are charged by a Preferred Provider during an office visit only **ONE** co-payment will apply toward the office visit charge and **ONE** co-payment will apply toward the office visit charge and **ONE** co-payment will apply toward diagnostic services.
- 8. Chiropractors:** You are covered for visits to your chiropractor and also for necessary related x-rays. The extent of coverage will be determined by the Plan based on an ongoing review on a case-by-case basis. **Maintenance care is NOT covered.**
- 9. Visiting Nurse Service:** You are covered for part-time or intermittent visits by participating nurses or by registered nurses from accredited participating nurse services. Care must be under the supervision of a physician.
- 10. Podiatry:** You are covered for the services of a podiatrist except for routine care of the feet.
- 11. Physiotherapy:** You are covered for the application of physio-treatment and/or treatment by osteopathic manipulation. This benefit is not available if it is covered by the Hospitalization portion of the Plan.
- 12. Radiation Therapy:** You are covered for radiation therapy given in or out of a hospital.

13. **Shock Therapy:** You are covered for shock therapy treatments given in or out of a hospital.
14. **Physical Therapy:** You are covered for visits to a physical therapist when the services provided are prescribed by a physician. The extent of the coverage will be determined by the Plan based on an ongoing review on a case-by-case basis.
15. **Spell of Illness:** A spell of illness begins when you are admitted as a patient to a hospital, birthing center or skilled nursing facility or receive home health care. When you are no longer a patient or receiving home health care for a period of at least 90 days for the same illness, the spell of illness ends and the benefits listed above are available to you again starting with the date of your new spell of illness.
16. **Oral and Injectable Substances:** The cost of oral and injectable substances for **routine preventive pediatric immunizations** will be a covered expense under the Preferred Provider portion of the East End Health Plan.
17. **Diabetic Education:** (*Please note, only individuals diagnosed as diabetics are eligible for this benefit.*) Counseling must be provided by a licensed and registered nutritionist or dietitian (R.D.). **In-Network (Reduced Fee Providers):** The Plan will cover the initial visit plus up to 2 additional follow-up visits during the first year. In addition, the Plan will pay for up to 2 visits during the second year and up to 2 visits during the third year. The total number of covered visits will be 7. No co-payment will be charged. In-network providers are currently listed in the “Reduced Fee Providers” section of the Medical PPO Directory under the heading “Dietary Counseling.”
18. **Infertility Benefit:** This benefit provides for Artificial Insemination and Assisted Reproductive Technology for employees and spouses only (Dependent children are not eligible for this benefit) as follows:

Covered Services and Supplies:

- § Patient education / program orientation,
- § Diagnostic testing,
- § Ovulation induction / hormonal therapy,
- § Surgery to enhance reproductive capability, and
- § Intrauterine insemination.

Please note that this benefit is available for Plan enrollees only at the Infertility Centers of Excellence as determined by the Plan’s Third Party Administrator. Infertility Treatments that are provided by any other provider are excluded from coverage under this Plan. Certain procedures are covered under the Infertility Benefit only with pre-certification and prior authorization from the Plan’s Third Party Administrator. The following procedures are covered only when the benefit has been pre-certified:

- § Assisted Reproductive Technology (ART) including:

- § In vitro fertilization and embryo placement,
- § Zygote intra-fallopian transfer,
- § Intracytoplasmic sperm injection for the treatment of male factor infertility,
- § Assisted hatching,
- § Micro-surgical sperm aspiration and extraction procedures including:
 - § Micro-surgical Epididymal sperm aspiration, and
 - § Testicular sperm extraction.
- § Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (that is, freezing and storage of sperm, eggs or embryos) for up to 6 (six) months.

Infertility Centers of Excellence

Based on clinical outcomes and criteria, the Plan's Third Party Administrator has identified a group of providers as leaders in reproductive medical technology and infertility procedures and has designated Infertility Centers of Excellence. These centers are available to provide the listed covered services and supplies. If you are authorized to receive benefits you have the choice to receive care at an Infertility Center of Excellence. Services not provided at an Infertility Center of Excellence are excluded from coverage under the Plan. Expenses for benefits provided at an Infertility Center of Excellence are payable in full, subject to the maximum lifetime benefits.

Maximum Lifetime Benefit

All non-prescription drug expenses for infertility treatments are subject to a lifetime maximum of \$25,000 per individual.

Exclusions and Limitations

- § Treatment of an individual who is able to achieve pregnancy, but is unable to carry it to full term.
- § Treatment for women who are menopausal or perimenopausal, unless they are experiencing premature menopause.
- § Any donor compensation or fees charged in facilitating a pregnancy.
- § Any charges for services provided to a donor in facilitating a pregnancy.
- § Experimental infertility procedures. (Infertility procedures performed must be accepted as non-experimental by the American Society of Reproductive Medicine).
- § In conjunction with the reproductive endocrinologist, decisions to exclude ART services may apply for persons who are clinically deemed to be high risk if pregnancy occurs (i.e. cystic fibrosis, multiple sclerosis, lupus, metastatic cancer).
- § Women with no reasonable expectation of becoming/maintaining pregnancy.
- § Storage of sperm, eggs or embryos for more than six months.
- § Surrogate pregnancy.

§ Recommendation from genetic screening reveals serious complications.

19. Outpatient Psychiatric Services: You are covered for the services of a physician or a physiologist licensed in the state where the service is rendered or by a certified and registered social worker.

REMEMBER: This benefit is subject to the Managed Care Program. The Third Party Administrator's Case Management Department must certify all covered services. You will not receive any Plan benefits and you will be responsible for the full cost of care unless all conditions and pre-certification requirements are met.

MAJOR MEDICAL EXPENSE PROGRAM

TWO DAYS PRIOR TO OBTAINING ONE OF THE FOLLOWING SERVICES, you must contact the Third Party Administrator's Case Management Department. The Case Manager will pre-certify medical necessity and coordinate cost-effective arrangements with participating providers in your demographic *area for*:

Home Nursing Services	Home Nutritional Feeding
Intravenous Home Therapy	Peritoneal Dialysis
Durable Medical Equipment	Hospice Care
Oxygen/Respiratory Equipment	Skilled Nursing Facility
Ambulance Services	Home Uterine Monitoring
Orthotics	Wound Care
Prosthesis	Physical, Occupational, Speech Therapy

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

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

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

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

Section at the beginning off the Plan Document.

ANNUAL DEDUCTIBLE:

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

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

COVERAGE:

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

COVERED MAJOR MEDICAL EXPENSES:

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

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

1. *Hospitals and Approved Facilities:*
 - A. Services of hospitals for which hospitalization benefits are provided are covered excluding:
 1. Charges for room and board and special services provided to you as an in-patient during a period for which hospitalization benefits are provided;

2. Any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;
 3. Charges for out-patient services covered by your hospitalization; **AND**
 4. Services not billed for by the hospital.
- B. Services of private proprietary hospitals for the treatment of mental and nervous conditions and alcoholism are paid in full up to the contracted rate for in-network facilities. For out-of-network facilities in-patient psychiatric care charges are covered at 80% of the hospital's semi-private rate, with a maximum covered charge of \$450 per day (subject to annual deductible).

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

- C. In-patient services by approved facilities, other than a hospital, for treatment of alcoholism and/or substance abuse are covered for a maximum total confinement of **seven weeks** in any calendar year.
- D. Out-patient services by approved facilities, other than a hospital, for treatment of substance abuse are covered up to a **maximum of thirty treatments** in a calendar year.

REMEMBER: You must comply with the Managed Care Program requirements for a hospital or approved facility admission. Refer to the details of how this program works in the Managed Care Program section of this booklet.

If and when it is determined that in-patient care is no longer medically necessary, benefits will cease and notice will be given to the hospital or approved facility and to the patient the day before your benefits end.

2. *Physicians:* Services of physicians are covered, except that:
- A. Services received on an in-patient basis for the treatment of mental and nervous conditions will be payable only during a period in which benefits are payable under the Plan for room and board;
 - B. Out-patient services for the treatment of mental and nervous conditions, will be payable as set forth in the "Out-Patient Psychiatric Services" segment.

3. *Nursing Services:* Services of a nurse are covered provided such services at home are:
 - A. Prescribed by a physician; AND
 - B. Rendered by a registered professional nurse (R.N.); OR
 - C. Rendered by a licensed practical nurse (L.P.N.); AND
 - D. Not rendered by someone who lives in your home or by a member of your immediate family.

The services rendered must be medically necessary and must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients. This does not include assistance with daily living, companionship or any other service which can be given by a less-skilled person, such as a home health aide.

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

4. *Nurse-Midwife Services:* Maternity services of a nurse-midwife are covered if the nurse-midwife is:
 - A. Licensed or certified to practice nurse-midwifery, AND
 - B. Permitted to perform the service under the laws of the state where the services are rendered.
5. *Chiropractors:* Services of a duly licensed chiropractor will be covered for:
 - A. Manual manipulation of the spine to correct a subluxation that can be shown by X-ray; and
 - B. Other services prescribed by a physician, **EXCEPT maintenance care.**
6. *Acupuncturist:* Services of a licensed acupuncturist will be covered for the treatment of certain types of medical conditions when prescribed by a physician. These services must be reviewed and approved by the Care Management Department of the Third Party Administrator prior to receiving the services.
7. *Podiatrists:* Services of duly licensed podiatrists for the treatment of:
 - A. Diseases
 - B. Injuries
 - C. Malformation of the foot

are covered, **EXCEPT** that those treatments or supplies that are listed as Exclusions under the Plan. The supplies covered under this benefit are subject to the Orthotics benefit parameters.

8. *Routine Health Exams:* For you (the employee), routine health exams are covered up to a maximum reimbursement of \$100 in a calendar year if you are age 50 or older. Covered spouses, age 50 or older, are covered for routine health exams up to a maximum reimbursement of \$50 in a calendar year. These benefits are not subject to a deductible or co-insurance.
9. *Hearing Aids:* Hearing aids, including examinations for and the fitting of, are covered up to a total maximum reimbursement of \$1,200 once every four years. Children of the age 12 and under are covered up to a total maximum reimbursement of \$1,200 once every two years. These benefits are not subject to deductible or co-insurance.
10. *Routine Newborn Child Care:* Physician's services for the routine care of a newborn child are covered up to a maximum payment of \$100. These benefits are not subject to a deductible or co-insurance.
11. *Durable Medical Equipment:* The rental, or purchase when appropriate, of durable medical equipment is covered if such equipment is customarily used for therapy and suitable for home use. In the case of purchased equipment, coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.
12. *Prosthetics:* Artificial limbs or other prosthetic devices, including replacement when it is functionally necessary to do so, are covered.
13. *Ambulance Service:* The following charges for ambulance services are covered medical expenses:
 - A. Up to \$50 of covered charges for professional (commercial) ambulance service without deductible or co-insurance. A balance of over \$50 will be covered under Major Medical subject to a deductible and co-insurance.
 - B. Charges of an organized voluntary ambulance service, up to a maximum of \$50 for under 50 miles, \$75 for 50 miles or over, are not subject to a deductible or co-insurance and are covered medical expenses.
14. *Eye Care Following Cataract Surgery:* The charges for one set of prescription eyeglasses or contact lenses and one eye exam are covered medical expenses following cataract surgery.
15. *Voluntary Sterilization:* Charges for voluntary sterilization are covered medical expenses.

16. *Miscellaneous Services:* The following services are covered under the Major Medical Program when not covered by your hospitalization plan:
- A. Diagnostic lab procedures and x-rays and X-ray or radiation treatments
 - B. Oxygen and its administration
 - C. Anesthetics and their administration
 - D. Blood transfusions, including the cost of blood and blood products; however, such costs will be covered medical expenses only to the extent that there is evidence, satisfactory to the Plan, that such supplies could not be obtained without cost.
 - E. Chemotherapy
 - F. Hemodialysis
17. *Professional Services For In-Patient Psychiatric Care:* Services rendered by a physician for in-patient psychiatric care in a hospital will be paid at 80% of Reasonable and Customary charges with a maximum covered charge of **\$75** per day, after the annual deductible is met.
18. *Hospital Emergency Room Service:* When the Plan determines that you received emergency care in a hospital Emergency Room as defined under the Out-Patient Services Section of Part II of this Plan Document, covered charges billed separately by outside providers contracted by the hospitals to perform services in the Emergency Room will be paid in full, subject to medical necessity and Reasonable and Customary but not subject to deductible, coinsurance or co-payment. Benefits available will be subject to the Plan maximum.
- Services provided by other specialty physicians in a hospital Emergency Room are considered under the Participating Provider Program or the Major Medical Program, depending upon where the physician participates.
19. *Pre-Donation Of Blood:* The cost (Reasonable and Customary allowance) to administer the pre-donation of blood prior to scheduled surgery will be a covered expense. A physician's statement will be required indicating that it was medically necessary, and the physician must state the quantity of blood to be donated. This expense will be subject to the deductible and co-insurance of the Plan.
20. *Orthotics:* Each claimant will be covered for only one orthotic claim during the calendar year. Charges will be reimbursed subject to the usual Reasonable and Customary guidelines, not to exceed \$275. These benefits are subject to the deductible and co-insurance of the Plan.
21. *Physical Therapists:* Services of a duly licensed physical therapist will be covered when

those services are prescribed by a physician. The extent of coverage will be determined by the Plan based on an ongoing review.

22. *Diabetic Education:*

Benefits are available only for a covered person with a diabetic condition. The Plan pays the allowable amount for diabetes self-management education, which includes education relating to proper diet, as specified below, to ensure the patient is educated as to the proper self-management and treatment of the diabetic condition. Benefits will only be provided for self-management education when:

- A covered person is initially diagnosed with diabetes;
- A Physician diagnoses a significant change in the diabetic symptoms or condition that requires changes in self-management; or
- It is determined that reeducation or refresher education is necessary.

The self-management education must be provided by:

- A physician, nurse practitioner or staff member during an office visit for diabetes diagnosis or treatment. When the self-management education is provided during an office visit, the one payment for the office visit will be inclusive of the payment for the self-management education;
- A certified diabetes nurse educator, certified nutritionist, or certified or registered dietician when referred by a physician or nurse practitioner. This education must be provided in a group setting. If it is determined that group education is not available in the covered person's area, benefits will be provided for the education when provided by a professional provider New York State Law requires the Plan to recognize; or
- A professional provider described above during a visit to a patient's home. Benefits will only be provided for such education in the home when it is determined that it is medically necessary.

This benefit is not subject to coinsurance or deductible.

OUT-PATIENT PSYCHIATRIC SERVICES

**(Subject to Out-Patient Mental Health, Alcoholism and Substance Abuse Program)
(See Part II - The Managed Care Program)**

If you see a non-participating provider, charges for out-patient psychiatric services are considered for benefits if provided by a physician or a psychologist licensed in the state where the service is rendered or by a certified and registered social worker.

In the case of out-patient psychiatric services, the following will apply:

1. **Crisis Intervention Coverage:** Up to \$60 of such covered charges will be payable in full (that is, not subject to a deductible or co-insurance) for each of three visits in a crisis.

Definition of Crisis: A crisis is defined as an acute emotional disturbance which results in a temporary inability to function in one's daily life. Examples of situations meeting this definition include:

- a. An acute psychotic reaction
- b. Loss of coping capacity
- c. Panic reaction
- d. Any situation endangering the patient, others or property

Such crisis would usually be precipitated by an adverse event:

- Loss of crucial person through death, divorce or separation
- Serious illness, sudden myocardial infarction (heart attack)
- Onset of disabling psychiatric symptoms
- A social trauma such as rape or robbery

A statement of necessity satisfactory to the Plan must be submitted by the provider in order for a period of treatment to be considered a crisis.

2. **Other visits will be payable at 80% of the lesser of the provider's fee or plan maximum:**

- a. The annual deductible amount, **AND**
- b. The resulting maximum payments per visit:

T **\$40** for the 1st through 30th visit

T **\$40** for later visits in the same period of treatment, upon further pre-confirmation by the Plan

Based on the statement of necessity, the Plan may determine that a later visit is a continuation of a prior period of treatment although separated from it by a period of

time of up to one year.

All continuous treatment visits are payable in accordance with the preceding schedule of benefits. Benefits will not revert to the first visit level of payments because the period of treatment enters a new calendar year. The sequence in the schedule will be followed for all continuous treatment visits. If your continuous period of treatment does enter a new calendar year, **you are not liable for a new annual deductible for these expenses.**

REMEMBER - This benefit is subject to the Managed Care Program. The Third Party Administrator's Case Management must certify all covered services. You will not receive any Plan benefits and you will be responsible for the full cost of care unless all conditions and pre-certification requirements are met.

NOTE - The Co-Insurance you pay for out-patient psychiatric services does **NOT** count toward meeting your \$900 Co-Insurance maximum. Services which are primarily directed toward raising the "level of consciousness," social enhancement, retraining, professional training or counseling limited to everyday problems of living are not covered. Under **NO** circumstances will psychotherapy which includes the satisfaction of requirements of professional training be considered as covered services.

MAMMOGRAPHY COVERAGE

The East End Health Plan covers mammographies performed by either a participating or non-participating provider when a medical condition is suspected or known to exist. In addition, mammographies are covered as part of routine preventive care when these services are provided by a participating provider.

Coverage for mammographies will also be available when provided by non-participating providers even if the mammography is done as part of routine preventive care. **The corresponding office visit fee, however, WILL NOT be covered.**

Coverage will be available under these conditions:

- T Upon the recommendation of a physician, a mammogram for covered persons at any age having a prior history of breast cancer, or whose mother or sister has a prior history of breast cancer;
- T A single baseline mammogram for covered persons 35 through 39 years of age;
- T An annual mammogram for covered persons 40 years of age or older.

If services are provided by a hospital, payment will be made by the hospitalization section of the Plan subject to the applicable co-payments. If services are provided by a non-participating provider, coverage is subject to the annual deductibles and co-insurance provisions.

GENERAL PROVISIONS

Hospitalization and Medical Benefits Exclusions and Limitations:

Charges for the following services and/or supplies are **NOT** covered Medical expenses.

1. **Prior Care:** Payment will not be made for services or supplies which you received before you became covered under this Plan.

2. **Care must be medically necessary.** Services, supplies or care you receive must be medically necessary in accordance with generally accepted medical standards as determined by the Plan and
 - a. consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury.
 - b. not solely for your convenience or that of your doctor or other provider; and
 - c. the most appropriate supply or level of service which can be safely provided to you.

The fact that a Physician may recommend that a covered person receive a surgical or a medical service or be confined to a Hospital does not mean:

- a. That such service or confinement will be deemed to be medically necessary; or
- b. that benefits under this Plan will be paid for the expense of such service or confinement:

The Plan will make a decision as to whether such service or confinement:

- a. is medically necessary in terms of generally accepted medical standards; and
- b. is qualified for benefits under this Plan.

3. **Medicines or Prescription Drugs.**

4. **Eye and Hearing Care: Payment will not be made for:** eyeglasses, contact lenses or hearing aids except as described in the list of Covered Medical Expenses.

5. **Cosmetic Surgery:** Payment will not be made for elective cosmetic surgery or for any complications which arise from elective cosmetic surgery or for any hospitalization in connection with such surgery or from its complications.

Benefits are available for reconstructive surgery if it is necessary to treat an infection or injury, provided that such infection or injury does not arise from cosmetic surgery. For a covered child, benefits are available for cosmetic surgery to treat a functional defect that is present from birth. A functional defect is defined as the loss of, or interference with, normal body function.

Cosmetic procedures and related services as those which are performed to reshape structure of the body in order to alter the individual's appearance or to alter the manifestations of the aging process.

Reconstructive procedures are related to services which are performed on a structure of the body to improve/restore bodily function or correct a deformity resulting from disease, trauma, congenital or developmental abnormalities or therapeutic processes.

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

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

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

7. **Alcohol/Substance Abuse Rehabilitation:** The hospitalization portion of the Plan will not make payment for services rendered in connection with a hospital stay or a portion of a hospital stay for alcoholism or drug addiction rehabilitation. Services by approved facilities other than a hospital for alcoholic rehabilitation will be covered.
8. **Worker's Compensation:** Payment will not be made for care for any injury, condition or disease if payment is available to you under a Worker's Compensation Law or similar legislation. Payments will not be made even if you do not claim the benefits you are entitled to receive under the Worker's Compensation Law. Also, payments will not be made even if

you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Worker's Compensation Law or similar legislation.

9. **Veteran's Facility:** Services or supplies rendered in a veteran's facility or which are provided under any governmental program (other than Medicaid) under which you are or could be covered.
10. **War:** Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared.
11. **Free Care:** Payment will not be made for any care if the care is furnished to you without charge. You are not covered for services rendered by a provider for which no legally enforceable charge is incurred.
12. **Services Performed by a Family Member:** Services which are provided by a father, mother, brother, sister, spouse or children will not be covered under the Plan. Supplies necessary for these services will be covered.
13. **Medicare:** Payment will be reduced by the amount available to you under the federal government's Medicare Program. *When eligible for primary Medicare coverage, you must enroll in Medicare and file for all benefits available to you under Medicare.*
14. **No-Fault Automobile Insurance:** Payment will not be made for any service which is covered by mandatory automobile No-Fault benefits. However, services not covered under No-Fault, such as when there is a deductible, will be covered. Benefits will not be provided if you or your qualified dependents are obligated under Law to be covered under a No-Fault policy and are not.
15. **Experimental/Investigative Procedures:** Services or supplies, including any hospitalization, in connection with such technology which are considered to be not medically necessary, experimental, investigative, obsolete or ineffective in terms of generally accepted medical standards as determined by The Plan with the advice of the Board of Trustees of the East End Health Plan in appropriate cases.

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

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

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

We may apply any or all of the following five criteria at our discretion in determining whether a technology is not medically necessary, experimental, investigative, obsolete or ineffective:

- a. Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition.

Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met.

- b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.
- c. Demonstrated evidence as reflected in the published peer reviewed medical literature must exist that, over time, the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.
- e. Proof as reflected in the published peer reviewed medical literature must exist that improvement in health outcomes (as defined in #c above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

- 16. Dental services or supplies provided by a Dentist:** However, you are covered for dental services and appliances necessary for the correction of damage caused by an accident provided the services are received within twelve months of the accident and while you are covered under This Plan. In addition, you are covered for oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under this Plan and which occurs while you are covered under This Plan. Extractions, dental cavities, periodontics (including but not limited to gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.

17. Services or supplies for the administration of anesthesia if the charges for surgery are not covered under This Plan.
18. Services or supplies to the extent they are not covered due to non-compliance with the requirements of the East End Health Plan for in-patient admission, Managed Care Program, Second Surgical Opinion Program, in-patient diagnostic testing or other pre-confirmation programs.
19. Routine services which are duplicative because they are provided by both a nurse-midwife and Physician.
20. Orthopedic shoes and other supportive devices and services for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except as described in the list of covered medical expenses.
21. Services or supplies, including cutting or removal, for treatment of corns, callouses, or toenails, except care which is medically necessary due to metabolic disease diagnosed by a physician.
22. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance policy issued to you.
23. Services rendered for medical summaries and medical invoice preparations.
24. Most Weight loss programs are not covered under East End Health Plan.
25. If you are hospitalized in New York State, the New York State Hospital Code requires the hospital to provide medically necessary nursing care. This includes the immediate availability of a registered professional nurse at the patient's bedside when necessary. Other states have similar requirements. Expenses for these in-patient nursing services are included in the hospitalization or rate Medicare pays the hospital. Therefore, expenses for such in-patient nursing services are not reimbursed under East End Health Plan coverage.
26. Services, supplies and associated fees rendered in connection with sperm banks are not covered.
27. Payment will not be made for services in connection with in-patient admissions or out-patient care in pain control programs. Payment will be made for medically necessary in-patient care and for covered out-patient services described elsewhere in this chapter.

COORDINATION OF BENEFITS

If a covered person is entitled to benefits for medical care and/or prescription drug benefits under this Plan and at least one other plan, the amount of benefits provided by this Plan for that care, if this Plan is the secondary Plan, may be reduced to the extent that the total benefits paid or provided by all plans during a Claim Determination Period are not more than the total of the allowable expenses that the person incurs in that period. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay the stated percentage of allowable expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligations to pay for the stated percentage of allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period. This will be done as set forth in the Order of Payment.

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

T **“Plan”** may include:

- a. Any group insurance, or any other method of coverage for persons in a group.
- b. An uninsured arrangement of group coverage.
- c. Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- d. Any governmental plan, but not including a state plan under Medicaid.
- e. Any plan required by law, but shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
- f. The medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.

T **“Plan”** shall NOT include:

- a. Blanket school accident coverage; or
- b. Hospital indemnity coverage.

“This Plan”: This term means that part of this plan which provides benefits for medical care. This term does NOT include vision care or hearing aid programs.

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

1. The plan does not have a Coordination of Benefits provision like this plan; **OR**

2. The Plan, in accord with Order of Payment, would determine its benefits first.

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

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

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

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

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

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

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

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

- a. First, the plan of the parent with custody of the child;
- b. Then, the plan of the spouse of the parent with custody of the child;
- c. Finally, the plan of the parent not having custody of the child.

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

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

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

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

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

HOW, WHEN AND WHERE TO SUBMIT CLAIMS

HOW TO CLAIM BENEFITS

When you require hospitalization, present your East End Health Plan Identification card to the hospital admitting clerk.

In most instances (the exceptions are admissions to foreign hospitals), claim forms are sent directly from the institution the Third Party Administrator. In those few cases where the hospital does not send a notice of claim, you must submit a claim directly.

The claim forms are then screened for completeness, medically coded, registered, checked for eligibility, reviewed for coverage and approved or rejected. When a completed report describing the services rendered is received from the hospital, a final review is made to determine the contract benefits available. The appropriate payment is made to the hospital.

HOW TO SUBMIT A CLAIM:

1. If you go to a Preferred Provider, all you have to do is assist in filling out that portion of the claim form which includes your personal information, name, address, identification number, etc. and sign the form. Your Preferred Provider fills out the remainder of the form and sends it directly to Third Party Administrator. The claim forms are in each Preferred Provider's office. You are responsible for the co-pay.
2. If you go to a non-preferred provider, refer to the instructions on the Major Medical claim form for the specific items or information required. A Major Medical claim form may be obtained from your district's Health Plan Coordinator or from the Third Party Administrator.

Have the physician or other provider fill in all the information asked for on the claim form and sign it. If the form is not filled out by the provider and itemized bills are submitted, they must include all the information asked for on the claim form. Missing information will delay the claim being processed. If you are submitting more than one bill for different providers, please be sure to attach a separate claim form for each provider of service. **DO NOT SUBMIT "BALANCE DUE" BILLS.**

If you or a family member has other coverage, please submit a copy of the other carrier's Explanation of Benefits (EOB).

If you are enrolled in **Medicare**, a “Medicare Explanation of Benefits” form must be submitted with the completed claim form and detailed bills for all items to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the “Explanation of Benefits” form since it cannot be returned. Failure to supply this information will result in a processing delay.

REMEMBER - If you are enrolled in Medicare for Primary coverage, bills must be submitted to Medicare first.

WHEN TO FILE A CLAIM:

1. If you use a Preferred Provider, your claim form should be signed by you when you incur the charges. Your Preferred Provider will then send it to the Third Party Administrator.
2. If you use a non-preferred provider, claims may be submitted at any time but not later than 90 days after the end of the calendar year in which covered medical expenses were incurred.

WHERE TO FILE A CLAIM:

Completed claim forms with supporting itemized bills, receipts, the “Statement of Payment” from other insurance carriers and the “Medicare Explanation of Benefits” form should be sent to the Third Party Administrator.

VERIFICATION OF CLAIM INFORMATION:

The Plan has the right to request from hospitals, approved facilities, physicians or other providers any information that is necessary for the proper handling of claims. If the Plan is unable to obtain the medical records, the Plan has the right to deny payment for that claim. The information will be kept confidential.

CLAIM INQUIRIES:

When you have a question about your claim, you may call the Third Party Administrator.

TERMINATION

Your coverage may terminate for any of the following reasons:

- a. East End Health Plan terminates the contract in accordance with the Trust Agreement
- b. Your district terminates the contract in accordance with the Trust Agreement
- c. Your employer fails to pay premiums
- d. You fail to pay premiums (if required)
- e. You or your covered dependents no longer meet the contract’s eligibility requirements (as defined in the “Eligibility” section)
- f. You or your covered dependents have engaged in fraud or intentionally made a false statement on an application or health claim form.

MISCELLANEOUS PROVISIONS

CONFINED ON DATE OF CHANGE OF OPTIONS:

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

- a. if the transfer is out of the Plan, and You are confined on the day coverage ends, the East End Health Plan will be responsible for the inpatient hospital claim only; and
- b. if the transfer is into the Plan, benefits are payable to the extent they are not paid through the former health insurance program.

TERMINATION OF COVERAGE:

1. Coverage will end when you are no longer eligible to participate in this plan. Refer to the General Information Section.
2. If this Plan ends, your coverage will end.
3. Coverage for a dependent will end on the date that dependent ceases to be a dependent as defined in the General Information Section.

If coverage ends, any claim which is incurred before your coverage ends, for any reason, will not be affected; also see the Continuation of Coverage Section.

REFUND TO THE PLAN FOR OVERPAYMENT OF BENEFITS:

If East End Health Plan pays benefits under this Plan for Covered Medical Expenses incurred on your account, and it is found that the Plan paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were repaid for all or some of those expenses by another source, the Plan will have the right to recover those costs from you. The amount of the refund is the difference between the amount of benefits paid by The Plan for those expenses and the amount of benefits which should have been paid by the Plan for those expenses.

If benefits were paid by East End Health Plan for expenses not covered by this Plan, the Plan will have the right to recover those costs from You. Please note that the Plan does reserve the right to withhold any recoveries from the cost of future benefit payments.

EAST END HEALTH PLAN

PART V

PRESCRIPTION DRUG COVERAGE

PART V

PRESCRIPTION DRUG PROGRAM

Your prescription drug benefits are separated into the following two programs and are subject to the Coordination of Benefits provision:

- T Retail Prescription Drug Plan
- T Maintenance Mail Order Prescription Drug Program

The dollar values of the co-payments for the prescription drug program are all identified in the Summary of Benefits Section at the beginning of the Plan Document.

RETAIL PRESCRIPTION DRUG PROGRAM

At the participating pharmacy, there is a set co-payment for brand name drugs, be they preferred or non-preferred, or generic drugs, however, the **Mandatory Generic Drug Feature will apply.**

Generic drugs have the lowest co-payment and are a safe alternative to brand-name drugs. You will pay a co-payment for generic drugs at the retail pharmacy for a 35 day supply and a co-payment for generic drugs via the mail order program for a 90 day supply.

Brand name drugs are significantly more expensive than generic drugs and, as a result, have a higher co-payment. For brand name drugs that administrator of the retail prescription drug program has classified as preferred, you will pay a co-payment at the retail pharmacy for a 35 day supply and co-payment via the mail order program for a 90 day supply. There are a number of drugs that do not have a therapeutic equivalent. These drugs will be included under the preferred drug co-payment. Should you have a question concerning a specific brand name drug, please contact the administrator of the retail prescription drug program. Their phone number is included in the Contacts Section at the beginning of the Plan Document.

Non-preferred drugs are brand name drugs which carry a higher cost and, therefore, require a higher co-payment. For brand name drugs that the administrator of the retail prescription drug program has classified as non-preferred, you will pay a co-payment at the retail pharmacy for a 35 day supply and a co-payment via the mail order program for a 90 day supply. It is important to note that no drugs have been included on this list unless there is a therapeutically equivalent brand name drug included on the preferred drug list. Should you have a question concerning a specific brand name drug, please contact the administrator of the retail prescription drug program. Their phone number is included in the Contacts Section at the beginning of the Plan Document.

In the unlikely event that you use a non-participating pharmacy, you must pay the full charge to the pharmacy and submit a direct reimbursement claim form. The administrator of the retail prescription drug program will reimburse you directly the same amount you would have reimbursed at a participating pharmacy. This may or may not cover the full charge.

QUANTITY OF DRUGS PER PRESCRIPTION

At any participating pharmacy you may receive up to a 30-day supply of an acute care drug and a 90-day supply of maintenance medications. Acute care drugs are those used to treat illness on a short term basis, while maintenance medications are taken regularly over a long period of time.

Participating pharmacies are located in all fifty states. Present your plastic card, along with your physician's prescription, to the pharmacist at the time you have your prescription filled or refilled. If your pharmacist has any questions regarding your coverage, he should call the administrator of the retail prescription drug program. Their phone number is included in the Contacts Section at the beginning of the Plan Document.

Prescription Drug Program Exclusions

- Contraceptives other than oral whether medication or device including Levonorgestrel (Norplant). Note that oral contraceptives are covered under the plan effective January 1, 2002.
- Viagra and other impotency drugs in excess of 6 pills per insured per month.
- Vitamins, singly or in combination. **Exceptions:** Calcitrol (e.g. Rocaltrol), Calcifediol (e.g. Calderol) and Dihydrotachysterol (e.g. Hytakerol) are covered.
- Charges for the administration or injection of any drug. Please note that coverage may be available under the medical benefit.
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances. Syringes are covered for diabetic use only. Please note that coverage may be available under the Durable Medical Equipment benefit.
- Cosmetic hair removal Products and Hair growth stimulants.
- Non-legend drugs other than insulin.
- Prescriptions which an eligible person is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Immunization agents, biological sera, blood or blood plasma. Please note that coverage may be available under the medical benefit.

- 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.
- Any refill dispensed after one year from the physician's original order.

MAINTENANCE MAIL ORDER PRESCRIPTION DRUG PROGRAM

The administrator of the mail order prescription drug program provides a prescription drug plan for those participants who regularly use maintenance drugs (long-term medications such as Inderal for hypertension, Insulin, test strips, syringes, etc. (excluding Glycometers) for diabetes, Feldene for arthritis). Through the administrator of the retail prescription drug program you may order your diabetic supplies with no co-payment. If you have any questions, please call the administrator of the retail prescription drug program. Their phone number is included in the Contacts Section at the beginning of the Plan Document.

MAIL ORDER PHARMACY

The dollar values of the co-payments for the maintenance mail order prescription drug program are all identified in the Summary of Benefits Section at the beginning of the Plan Document. **The Mandatory Generic Drug Feature will apply.** You may receive up to 90-day supply under the plan. For forms to utilize the maintenance mail order prescription drug program, please contact your district's Health Plan Coordinator.

EAST END HEALTH PLAN

PART VI

VISION CARE BENEFITS

PART VI

VISION CARE BENEFITS

The Vision Care Benefits Program is designed to provide reimbursement for expenses incurred in the care and correction of vision related problems. The program covers not only glasses, frames and contact lenses, it also offers an annual allowance for preventive vision care examination by either a licensed optometrist or ophthalmologist. Benefits are available to covered enrollees of the Plan every twelve months. Benefits include a routine eye examination, including dilation as professionally indicated and, a complete pair of eyeglasses, or contact lenses, in lieu of eyeglasses.

The Vision care portion of your East End Health Plan coverage is basically broken down into two parts.

1. **Out-of-Network Benefits:** The Plan pays for vision services based upon a fixed fee schedule. You are responsible for any balance due the provider of the services.

To obtain payment for services performed by the Non-Network Provider, please complete a vision claim form and return it with your accompanying receipts to the Plan's Vision Plan Administrator.

You will receive a check reimbursing you up to the allowable expense.

2. **In-Network Benefits:** Network providers are an option added to the plan through the Plan's Vision Benefit Administrator. When you use a network participating provider, you can receive a paid in full benefit, including a complete eye exam, frame and lenses or contact lenses in lieu of eyeglasses. A one year warranty is given on all Plan-supplied eyeglasses.

The Network Providers are licensed doctors who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. To locate the Network Provider nearest to you, just call the Vision Plan Administrator.

Once you have selected the Network Provider of your choice, simply call the Provider's office to schedule an appointment. Identify yourself as a participant in the East End Health Plan Vision Care Program. Provide the office with the member's Social Security number and the year of birth of any covered children needing services. The Provider's office will verify your eligibility for services and no claim forms are required.

**SCHEDULE OF BENEFITS
(Non-Participating Provider)**

“Vision Care” for the purpose of this Policy shall mean an evaluation performed by a licensed Optometrist or Ophthalmologist when the Insured has no particular symptoms but feels the need of a routine eye examination which includes a survey of the principal visual functions.

PROCEDURE:	Benefit
1. Eye examination.	\$30.00
2. Single vision lenses with frames.	\$30.00
3. Bifocal lenses and frames.	\$60.00
4. Trifocal lenses and frames.	\$110.00
5. Contact lenses	\$110.00

**SCHEDULE OF BENEFITS
(Participating Provider)**

Any frame from the special selection of designer frames displayed on the “Tower Collection” in every participating doctor’s office is available under the Plan with no co-payment. Some spectacle lens types are also available with no-co-payment (please note that some lens types are available only at an additional charge). Contact lenses are available in lieu of eyeglasses are available under the Plan and require either a \$25.00 or \$45 co-payment toward standard, soft, daily-wear disposable or planned replacement contact lenses. New disposable contact lens wearers will receive an initial supply (two multi-packs) of lenses along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive four multi-packs of lenses.

You are also entitled to the following options at no cost to you, including:

- Plastic or glass single vision, bi-focal or tri-focal lenses.
- Glass grey #3 prescription lenses.
- Oversized lenses.
- Post-cataract (lenticular) lenses.
- Fashion, sun or gradient tinted plastic lenses.
- Polycarbonate lenses (for dependent children and monocular patients).

The following optional items may be selected at the time you receive your eyeglasses at significantly value priced co-payments which should be paid by you directly to the doctor.

	<u>Item</u>	<u>Co-Payments</u>
<input type="checkbox"/>	Premier Frame	\$20.00
<input type="checkbox"/>	Progressive Addition Lenses - Standard	\$50.00
<input type="checkbox"/>	Progressive Addition Lenses - Premium	\$90.00
<input type="checkbox"/>	Blended Segment Lenses	\$20.00
<input type="checkbox"/>	PGX Single Vision Lenses	\$20.00
<input type="checkbox"/>	PGX Multifocal Lenses	\$20.00
<input type="checkbox"/>	Scratch Resistant Coating - Single Vision	\$20.00
<input type="checkbox"/>	Scratch Resistant Coating - Multifocal	\$20.00
<input type="checkbox"/>	Ultraviolet Coating	\$12.00
<input type="checkbox"/>	Polycarbonate Lenses	\$30.00
<input type="checkbox"/>	Glare Resistant Treatment	\$55.00
<input type="checkbox"/>	Polarized Lenses	\$75.00
<input type="checkbox"/>	High Index Lenses	\$55.00
<input type="checkbox"/>	Plastic Photosensitive Lenses	\$65.00
<input type="checkbox"/>	Anti Reflective Coating - Premium	\$48.00
<input type="checkbox"/>	Intermediate Vision Lenses	\$30.00

Lenses and frames not available through the Plan may be obtained from a participating doctor, however, an additional charge may apply. An allowance from the following schedule will be deducted from the purchase price.

<input type="checkbox"/>	Single Vision	\$14.00
<input type="checkbox"/>	Bifocal	\$23.00
<input type="checkbox"/>	Trifocal	\$32.00

Frame: \$14.00

Contact Lenses: \$45.00

CONTACT LENSES: Standard, soft daily wear lenses are available through the Plan. A care kit for proper cleaning and sterilization of your lenses will be supplied, as well as all necessary visits for proper fitting. Replacement contact lenses and contact lens insurance are not included in the program. **Please note:** Contact lenses can be worn by most people, but not all. Once the contact lens option is selected and the lenses are fitted they may not be exchanged for eyeglasses. Each beneficiary may receive either a pair of contact lenses or eyeglasses, but not both. If Plan supplied contact lenses are fitted, a \$25.00 co-payment, paid directly by you to the doctor is required. If you need or select contact lenses other than those available through the Plan a \$45.00 allowance will be applied toward their cost. You will be required to pay all additional

charges for the contact lenses, fittings and recommended follow up care.

Medically necessary contact lenses for the correction of Keratoconus - Members will receive an annual paid-in-full allowance up to a maximum of \$500 for medically necessary contact lenses for the correction of Keratoconus with prior approval. Any amounts due over \$500 shall be borne by the member.

DEFINITIONS:

“Injury” wherever used herein means accidental bodily injury resulting directly and independently of all other causes in expense covered by this policy and incurred after the effective date of coverage of the Insured whose injury is the basis of the claim.

“Sickness” wherever used herein means illness or disease resulting in expense covered by the Policy and incurred after the effective date of coverage of the Insured whose sickness is the basis of the claim.

“Optometrist” for the purposes of this Policy shall mean an individual, duly licensed by the appropriate State Regulatory authority who specializes in the measurement of degrees of visual powers by refraction, without the aid of a cycloplegic or mydriatic.

“Ophthalmologist” for the purposes of this policy shall mean a duly licensed Doctor of Medicine specializing in diseases and refractive errors of the eye.

“Vision Survey” for the purpose of this policy shall mean an evaluation performed by a licensed Optometrist or Ophthalmologist when the Insured has no particular symptoms but feels the need of a routine eye examination which includes a survey of the principal visual functions.

No benefit shall be payable except as otherwise provided herein or on account of:

1. services for which no charge is made or for which the Insured is not required to pay or any eye examinations furnished by or payable under or for any government, Federal or state, dominion or provincial, or any positical subdivision thereof, or any glasses or frames for which the Insured has been or may be reimbursed under any group hospitalization or medical expense reimbursement insurance plan, to the extent of any such payment or reimbursement,
2. charges for services due to occupational accidents or sickness covered by workmen’s compensation,
3. more than one pair of lenses or examinations per person per 12 month period,
4. contact lenses except after cataract surgery or when the persons’ visual acuity is not corrective to 20/70 by use of conventional types of lenses, or when provided for cosmetic

purposes,

5. tinted glasses unless specifically prescribed because of medical or occupational reasons,
6. safety glasses or goggles,
7. services performed by an Optometrist or Ophthalmologist beyond the scope of their applicable licenses.

EAST END HEALTH PLAN

PART VII

CLAIMS APPEAL PROCESS

PART VII
CLAIMS APPEAL PROCESS

Introduction:

The East End Health Plan has the responsibility for payment of Plan benefits. The East End Health Plan has designated authority in this regard to the Third Party Administrator to handle the Plan's day-to-day implementation and processing of claims.

Application For Claim:

Any claims by a Participant for Benefit shall be submitted to the Third Party Administrator on the prescribed forms. Although the East End Health Plan is a governmental plan and therefore is exempt from the Employee Retirement Income Security Act (ERISA) provisions, similar principles will guide the plan in the administration of claims appeals. The Third Party Administrator shall be responsible for reviewing and initially judging such claim and provide full and fair review of the decision on such claim. Any legal action arising out of the denial in whole or in part of such claim shall be the responsibility of the East End Health Plan.

Limitations:

Notwithstanding anything in the Plan to the contrary, no benefits shall be payable under the Plan to any Participant who fails to submit a claim for benefits hereunder within ninety (90) days after the date covered charges were incurred or the beginning of the period, as the case may be, with respect to which the claim is made; provided that the East End Health Plan (or its delegate for claims payment purposes), in its sole discretion, may accept a claim after such time has elapsed if extenuating circumstances prevented the Participant from making a claim during such period. Each Participant or other interested person shall file with the Third Party Administrator such pertinent information as they may specify or provide, and in such a manner and form as they may specify or provide; and such person shall not have any rights or be entitled to any benefits or further benefits hereunder, as the case may be, unless such information is filed by the Participant or on the Participant's behalf.

Each Participant claiming benefits under the Plan shall supply, at such times and in such manner as the Third Party Administrator, in its sole discretion, may require written proof that covered expenses were incurred or that the benefit is covered under the Plan. If the Third Party Administrator, in its sole discretion, shall determine that a Participant or Covered Dependent has not incurred a covered expense or that the benefit is not covered under the Plan or, if the Participant or Dependent shall fail to furnish such proof as is requested, no benefit or no further benefits hereunder, as the case may be, shall be payable to such Participant or Dependent.

In processing any claim made for benefits under the plan, the Third Party Administrator, in accordance with the Plan Benefits, at its sole discretion, shall have the right, at the expense of the East End Health Plan, to have the Participant or Dependent claiming benefits hereunder examined or to have a physician designated by it, examine such a Participant or Dependent as often as is determined to be reasonably necessary, and in the case of death to have an autopsy conducted where not precluded by law.

Notification of Decision:

Notice of a decision by the Third Party Administrator with respect to a claim shall be furnished to the claimant within thirty (30) days following the receipt of a satisfactory proof of claim by the Third Party Administrator. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished by the Third Party Administrator to the claimant prior to the expiration of the initial thirty (30) day period. The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim shall be furnished. Commencement of benefit payments shall constitute notice of approval of a claim to the extent of the amount of the approved benefit. If such claim shall be wholly or partially denied, such notice shall be in writing and worded in a manner calculated to be understood by the claimant, and shall set forth: (a) the specific reason or reasons for the denial; (b) specific reference to pertinent provisions of the Plan on which the denial is based; (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary and (d) an explanation of the Plan's claims review procedure. If the claimant is not in agreement with the Third Party Administrator's decision or, if the Third Party Administrator fails to notify the claimant of the decision regarding the claim in accordance with this Section, the claimant shall then be permitted to proceed with the claims review procedure provided herein.

Claim Review Procedure:

Level I

Within sixty (60) days following receipt by the claimant of notice of the claim denial, or within sixty (60) days following the close of the thirty (30) day period referred to herein, if the Third Party Administrator fails to notify the claimant of the decisions within such thirty (30) day period, the claimant may appeal denial of the claim by filing a written application for review with the Third Party Administrator.

Upon receipt of the written application for review, the Third Party Administrator will review the claim and render a decision to either pay the claim or deny the claim. Prior to the decision of the Third Party Administrator regarding an appeal pursuant to this Section, the claimant shall be given an opportunity to review pertinent documents and to submit issues and comments in writing to be considered in reviewing the claim.

The request shall be made in writing and filed with the Third Party Administrator within sixty (60) days after delivery to the claimant of written notice of the decision. Such written request for review shall contain all additional information, which the claimant wishes the Third Party Administrator to consider. Following such request for review, the Third Party Administrator shall fully and fairly review the decision denying the claim.

The Third Party Administrator may hold a hearing or conduct an independent investigation of the merits of the denied claim and promptly, within sixty (60) days following receipt by the Third Party Administrator of the request for review, or within one hundred and twenty (120) days after such receipt in a case where there are special circumstances requiring extension of time for reviewing denied claim, shall render the decision to the claimant in writing.

In the rare situation that an emergency condition takes place in an inpatient setting outside of the emergency room, the enrollee may appeal a decision that physician services were provided by out-of-network physicians if there is clear evidence that the services were provided on an emergency basis and that there was no choice by the enrollee regarding the physicians that were providing the services. In such a case, the Plan will provide benefits up to 100% of the reasonable and customary reimbursement for those services.

Level II

If the claimant is still not in agreement with the resolution of the claim, it will be referred to the Medical Director for review. If the Medical Director approves the claim, it is given back to the examiner for processing. If the Medical Director denies the claim, the Medical Claim Supervisor will refer the case to the Third Party Administrator's Claims Appeal Committee for review. The Claims Appeal Committee will meet promptly to review any claims that have been referred. The Claims Appeal Committee will notify the Claimant of their decision. If the claim is denied the claimant will be notified as to the process to follow, if they choose, for the EEHP's Trustees Appeals Committee to hear the case.

Level III

REVIEW BY TRUSTEES APPEALS COMMITTEE

The claimant who is dissatisfied with the Third Party Administrator's Appeal Committee decision on a claim can make an appeal to the EEHP Trustees Appeals Committee herein after referred to as the "Committee".

The claimant must submit a written request for review within 30 days after receiving written denial of the claim or portion of the claim from the Third Party Administrator, as a result of the Level II review. An extension of the 30-day time limit may be granted, based on extenuating circumstances, at the sole discretion of the Committee. The claimant or duly recognized representative must send such notice to the attention of the "EEHP Trustees Appeals Committee" via the Third Party Administrator.

The Third Party Administrator will prepare a file for each appeal to be reviewed by the Committee in such a fashion that the privacy and confidentiality of the claimant is not compromised. The Committee shall review all data pertinent to the claim, and may seek outside professional medical consultation, and may require claimant to submit additional medical evidence to support the claim. The Committee shall exercise prudent and reasonable judgment to render a fair and impartial decision on the claim.

The Committee will report to the Board of Trustees at the next regularly scheduled meeting with their recommendation regarding the disposition of the claim. The report to the Trustees will provide a summary of the claim, the basis for the original denial by the Third Party Administrator, the Committee's activities regarding the appeal, the Committee's recommendation and the basis for the recommendation.

The EEHP Trustees will act on the recommendation of the Committee within 90 days of the receipt of the claimant's written request for appeal. If the Trustees determine extenuating circumstances exist so as to require immediate notice to the claimant, a special meeting of the Board of Trustees may be called to act on the recommendation of the Committee.

The Committee will notify the Third Party Administrator of the EEHP Board of Trustee's final decision. The Third Party Administrator will notify the claimant, in writing, regarding the EEHP Trustees final decision. If the EEHP Trustees approve the claim it will be submitted to the Third Party Administrator for processing.

EAST END HEALTH PLAN

PART VIII

IMPACT OF MEDICARE ON THE EAST END HEALTH PLAN

PART VI

IMPACT OF MEDICARE ON THIS PLAN

Definitions:

- Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.
- Primary Payor** means the plan that will determine the medical benefits which will be payable to you first.
- Secondary Payor** means a plan that will determine your medical benefits after the primary payor.
- Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.
- Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the General Information section of this book.
- You will be considered **disabled** if you are eligible for Medicare due to your disability.
- You will be considered to have **end stage renal disease** if you have permanent kidney failure.

COVERAGE

When you are eligible for primary coverage under Medicare, the benefits under this plan will change.

*Please refer to the General Information section of this book for information on when you **must** enroll for Medicare and when Medicare becomes your **primary** coverage. **If you or your dependent is eligible for primary Medicare coverage - even if you or your dependent fails to enroll - your covered medical expenses will be reduced by the amount available under Medicare, and this Plan will consider the balance for payment, subject to co-payment, deductible and co-insurance.***

- A. Retired Employees and/or their Dependents** - If you or they are eligible for primary coverage under Medicare - even if you or they fail to enroll - your covered medical expenses will be reduced by the amount that would have been paid by Medicare, and the East End Health Plan will consider the balance for payment, subject to co-payment, deductible and co-insurance.

If the provider has agreed to accept Medicare assignment, covered expenses will be based on either the provider's reasonable charge or the amount approved by Medicare. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations.

No benefits will be paid for services or supplies provided by a skilled nursing facility.

B. Active Employees and/or their Dependents -This Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents unless end stage renal disease provisions apply. Medicare will be the secondary payor. As the primary payor, the East End Health Plan will pay benefits for covered medical expenses under this plan; as secondary payor. Medicare's benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

The only way you can choose Medicare as the primary payor is by canceling this Plan. If you do so, there will be no further coverage for you under this Plan.

C. Disabled Employees and/or Disabled Dependents - If you or your enrolled dependent is disabled, you or your dependent may be eligible for Medicare in accordance with the provisions of the Social Security Act. During any period in which you or your disabled dependent is eligible for primary coverage under Medicare - even if you or your dependent fails to enroll - covered medical expenses will be limited to that part of such expenses for which benefits are not available in any form under the Act as evidenced by a statement to that effect from the Social Security Administration.

D. Employees, Retirees under age 65 and/or Dependents eligible for Medicare due to End Stage Renal Disease. - For those who are eligible for Medicare due to end stage renal disease, the insurer (East End Health Plan) which provided primary benefits before the onset of end stage renal disease is the primary insurer for the first 30 months of treatment, then Medicare becomes primary. You must have Medicare coverage in effect at the end of the 30-month period to avoid a loss in benefits. Special provisions may apply. Please see the general information section.

The benefits described are subject to the terms of the contract issued. If any conflict should arise between this explanation and the provisions of the plan document or if any provision is not described or only partially described, the terms of the actual plan documents or other applicable documents will govern in all cases.

EAST END HEALTH PLAN

PART IX

USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

**EAST END HEALTH PLAN AMENDMENT TO
PLAN DOCUMENT REGARDING USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

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

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

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

- ! Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual’s claim);
- ! Coordination of benefits;
- ! Adjudication of health benefit claims (including appeals and other payment disputes);
- ! Subrogation of health benefit claims;
- ! Establishing employee contributions;
- ! Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- ! Billing, collection activities and related health care data processing;
- ! Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- ! Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- ! Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- ! Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- ! Reimbursement to the plan.

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

- ! Quality assessment;
- ! Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- ! Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- ! Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- ! Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- ! Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- ! Business management and general administrative activities of the Plan, including, but not limited to:
 - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (b) customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - § resolution of internal grievances; and
 - § due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

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

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

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

C. Adoption of Third Party Administrators' and Pharmacy Benefits Managers' HIPAA Privacy Policies and Procedures

The Trustees of the EEHP adopt the policies and procedures of its Third Party Administrators and Pharmacy Benefits Manager, with respect to all HIPAA privacy requirements for the use and disclosure of PHI and Individual rights with respect to PHI including but not limited to:

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

D. For Purposes of This Section The Board of Trustees of the East End Health Plan Is the Plan Sponsor.

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