THE EAST END HEALTH PLAN

PLAN DOCUMENT
Revised: July 2023

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 administered by a Third Party Administer (TPA), Empire Blue Cross Blue Shield (BCBS), 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 the EEHP's Third Party Administrator and Prescription Benefit Manager
- 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
☐ Enrollment	District's Health Plan Coordinator	District's Phone Number
☐ Eligibility		
☐ Benefits, ID Cards		
☐ Benefits Management	Empire Blue Cross Blue Shield Box 1407 Church Street Station New York, NY 10008-1407 www.empireblue.com/eehp	1-844-230-4720
☐ Pre-Admission Certification		
☐ Inpatient Hospital Confinement		
☐ Mental Health and Substance Abuse Program		
☐ Durable Medical Equipment over $1,000		
☐ Home Health Care		
☐ Skilled Nursing Facility		
☐ Hospitalization	Empire Blue Cross Blue Shield Box 1407 Church Street Station New York, NY 10008-1407 www.empireblue.com/eehp	1-844-230-4720
☐ Preferred Provider Network		
☐ Medical Claims		

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

QUESTIONS ABOUT	CONTACT/ADDRESS	PHONE NUMBERS
☐ Prescription Drug Retail Pharmacy	ProAct 633 Route 298, 2nd Floor East Syracuse, NY 13057 www.proactrx.com	1-877-635-9545
☐ Prescription Drug Mail Order	ProAct / Health Direct Pharmacy 31 East Main Street Gouverneur, NY 13642 www.healthdirectpharmacy.com	1-866-287-9885
☐ Medicare	Contact your local Social Security Office - or -	1-800-772-1213
☐ Vision Plan	Davis Vision Vision Care Processing Unit PO Box 1525 Latham, NY 12110 www.davisvision.com	1-800-999-5431

If you have difficulty reaching any of the above telephone numbers, call the East End Health Plan at 1-631-687-3140.

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:

- Be expected to work at least three months.
- Work a regular schedule of 20 hours or more a week, **OR**
- Be in one of the following categories:
  - A local elected official
  - A paid member of a public legislative body
  - An elected member of a school board
  - Be paid an annual salary of $2,000 or more per year, **OR**
  - Receive your major source of family income from public employment.

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:

- *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.

- *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.

- *Your dependent children who are over age 19 but less than age 26 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.

- *Your dependent children who are above the age of 26 but less than age 29 who are enrolled under the NYS Young Adult Option.* The Young Adult Option is available to your adults who meet all of the following eligibility requirements:
  - Be a child, adopted child, or stepchild of an East End Health Plan enrollee (including those enrolled under COBRA).
  - Be age 29 or younger.
  - Be unmarried.
  - Not be insured by or be eligible for coverage through the young adult's own employer-sponsored health plan, whether insured or self-insured, provided that the health plan includes both hospital and medical benefits.
  - Live, work or reside in New York State.
  - Not be covered under Medicare.

  In addition, the young adult does not need to live with the parent, be financially dependent upon the parent, or be a student. A young adult's eligibility for health insurance coverage through a former employer under Federal COBRA or State continuation coverage does not disqualify the young adult from electing this option. Children of the young adult are not eligible for coverage under this option. The young adult's parent does not need to have family coverage, nor is the young adult required to have been previously covered as a dependent under the East End Health Plan, to be eligible to enroll is this option.

  The young adult will have to pay the Plan designated Young Adult Option premium on a monthly basis to maintain coverage.

- *Disabled dependents:* Your unmarried children age 26 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 before age 26 while covered as a full-time dependent, 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 26th birthday.

- *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:

- 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.

- The partners share joint responsibility for the household.
- Neither partner is married or legally separated from anyone else.
- The partners are each at least eighteen (18) years of age and mentally competent to consent to this declaration.
- The partners are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they legally reside.
- 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.)
- At least four of the following are true. Proof of at least two of the following is required to be submitted:
  ♦ 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:

- Unmarried;
- Primarily dependent on the employee for support (the employee must provide more than 50% of the child's support);
- Permanently residing in the employee's household;
- Meet the age and any other applicable requirements of the plan for benefits; and
- 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.

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

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:

- You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of three months.

- 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, Workers '

Compensation, or retirement allowance.

- 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 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
- You qualify for and receive income through Workers' Compensation.

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 East End Health Plan, c/o Eastern Suffolk BOCES, 201 Sunrise Highway, Patchogue, NY 11772.

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 East End Health Plan 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.

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 serious. 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 When 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 of the retirement system, and are at least 55 years of age and if last entry into service was PRIOR TO September 1, 1983 OR you are 62 years of age and if last entry occurred ON OR AFTER September 1, 1983, **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 in accordance with your district's requirements before your coverage again becomes effective. Check with your district's Health Plan Coordinator regarding the required waiting period.

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:

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.

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.

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

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.

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 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 will 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.

> **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. 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:

- the death of the employee;
- the termination of the employee's employment for reasons other than gross misconduct or reduction in the employee's hours of employment;
- a divorce or legal separation from the employee; or
- 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:

- the death of the parent employed by the participating school district;
- the termination of employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment with the participating school district;
- the divorce or legal separation of the dependent child's parents;
- the entitlement to Medicare of the parent employed by the participating school district; or
- 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, ineligibility for dependent coverage or in the event of termination or reduction in hours of employment.

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:

- The employee's participating school district no longer provides group health benefits coverage to any of its employees;
- The covered person fails to make timely payment of any premium due;
- 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;
- After electing continuation coverage, the covered person becomes entitled to Medicare.

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. 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.

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 of membership in the class or classes eligible for coverage, the employee may continue coverage for him/herself and eligible dependents, subject to the following.

- 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.

- The covered person must pay the monthly premium 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.

- Coverage will terminate at the earliest of the following:

    - the date 36 months after the covered person's coverage would have terminated because of termination of employment or membership;

    - The date to which premiums are paid, if the covered person fails to make a timely payment;

    - 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; or

    - 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.

- 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.

- 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:

- the covered person has used all the Plan benefits available;

- the Plan Administrator determines that the covered person is no longer totally disabled;
- the covered person reaches the lifetime maximum amount payable under the Plan; or
- 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.

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). You are automatically enrolled in Part A at age 65. This will help pay for in-patient hospital care, in-patient care in a skilled nursing facility, home health care, and hospice care.

Part B (medical insurance). You are not automatically enrolled in Part B, but should enroll in Part B upon turning age 65 or becoming disabled as defined by Medicare so that you will not face large out-of-pocket costs if you do not enroll. The Plan requires retirees, vestees and dependent survivors to be enrolled in Medicare Parts A and B when first eligible. The Plan also requires your dependents to be enrolled and entitled to receive medical benefits when first eligible even if also covered through another employer's group plan, ("entitled to receive medical benefits" means the dependent has Medicare in effect and could submit claims to Medicare and receive reimbursement). Medicare Part B will 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.**

If you are an active employee (not retired or not in vested status), 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 only, up until your spouse turns 65, not enrolling in Medicare will not dramatically reduce your benefits. However, if you are either a retired employee or a vestee, your spouse must enroll in Medicare and Medicare will be primary for your spouse.

It is the member's responsibility to be familiar with the Medicare rules and to act accordingly.

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, and 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 that are under age 65 and not disabled.

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

If you have family coverage, Medicare becomes primary for your covered dependents as soon as they become eligible for Medicare for any reason. Until then, the Plan remains primary for the dependent.

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.

ENROLLING IN MEDICARE:

As An ACTIVE Employee Age 65 Or Over:

Since as an active employee the 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 or leave the payroll as a vestee 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**. For retirees, vestees and dependent survivors, and their dependents under age 65, Medicare becomes primary when you turn 65 or before 65 if you become eligible because of a disability. Until then, the Plan remains primary. If you have family coverage, Medicare becomes primary to the Plan for your covered dependents as soon as they become eligible for Medicare for any reason. Until then, the Plan remains primary for the dependent.

A dependent who is covered under the Plan policy of a retiree, vestee, or dependent survivor must also be enrolled in Medicare Parts A and B when first eligible for Medicare coverage that is primary to the Plan. A dependent is eligible for Medicare when he or she: (1) is age 65 or older; or (2) regardless of age, has been entitled to Social Security Disability Benefits for more than 24 months; or (3) regardless of age, has end stage renal disease and has completed Medicare's waiting period of up to three months and the 30-month coordination period. If a dependent fails to enroll in Medicare and have both Parts A and B in effect when first eligible, the dependent's Plan Benefits will be dramatically reduced. The Plan will not provide any benefits for services that Medicare would have paid.

If you or your dependent do not enroll in Medicare Part A and Part B when first eligible, 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 the East End Health Plan as you had before you were 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:

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

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.

Example 4: **The provider opts out of Medicare and/or is considered an out-of-network provider under a Medicare Part C Plan.**

Step 1. Because the provider does not participate with Medicare, in this scenario you have the responsible of coordinating the entire claims submission

process. You would first have to submit a claim directly to Medicare and await a denial for that claim because the provider does not participate with Medicare.

Step 2. You then must file a claim form with the Third Party Administrator enclosing your bill from the provider and the Medicare denial statement. The Third Party Administrator will send you a check for any reimbursement due you under the East End Health Plan.

Step 3. The reimbursement of this claim will be based on the Third Party Administrator's estimate of what the Medicare payment would have been to the provider. Any additional monies due to the provider in excess of the money paid to you by the Third Party Administrator will have to be paid by you directly to the provider along with the amount paid to you directly from the East End Health Plan.

Medicare Crossover:

Medicare Crossover is the process by which Medicare automatically forwards medical claims to the EEHP's Third Party Administrator for processing. In effect, a Medicare recipient has *One Stop Shopping* for submitting medical claims and there is no need for you to file twice! Medicare Crossover is available to any Medicare-primary EEHP enrollee. That is, Medicare pays first, then claims are submitted electronically to the TPA. It is available to both enrollees and their Medicare-eligible dependents, if they do not have group coverage from another source.

Based on agreements with Medicare, the TPA can receive an electronic copy of your Explanation of Medicare Benefits (EOMB) statement directly from the Medicare processor. Upon receipt of the EOMB, the TPA will process the balance of your claim under the provisions of the EEHP. This eliminates the need for you or your physician to make a copy of the EOMB and submit a second claim to the TPA for Medicare.

To take advantage of this streamlined process, please complete and submit the Medicare Crossover Enrollment Form. Your spouse may also participate in this process if she/he is eligible for Medicare *and does not have any other group medical benefits coverage from another source.* You can verify that the automated crossover is in place if you receive an EOMB statement from your Medicare carrier which states that your claim has been forwarded to your secondary insurance carrier. Until this message appears on your Medicare EOMB, it is important that you continue to file secondary claims with the TPA for that portion of the charges. If your Medicare carrier does not send you an EOMB, you will know that your claim was crossed over if your EEHP Explanation of Benefits includes a summary of Medicare benefits. This process does not apply to prescription drug expenses. Claims for those expenses should continue to be filed as they have in the past.

CLAIMS DEADLINE:

East End Health Plan claims for out-of-network claims must be submitted no later then one year after the date of service.

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. You must notify your former employer in writing if you will be residing outside the United States. Your former employer will discontinue your Part B reimbursement during the time you continue to reside outside of the United States and the East End Health Plan is primary.

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 local 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. When East End Health Plan resumes paying primary coverage under these circumstances, neither your former employer nor your new employer will reimburse your Medicare Bart B premium.

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 <u>automatically.</u> You must submit a form to the District's Health Plan Coordinator of any changes, such as:

Your Family Coverage:

- You marry or divorce

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

Your Status Changes

- You are going to retire from your District
- You are affected by a layoff
- You leave the employment of the District
- You are going on Leave Without Pay
- You want to continue your health coverage while in a 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

You Should Contact Your District's Health Plan Coordinator If:

- 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

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.

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. 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

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 inpatient 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 FIVE PARTS:

1 - 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 Advisor 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, the member has the right to appeal the decision as is detailed in this Plan Document in the Section titled "Claims Appeal Process".

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 $200 of the total billed hospital charges

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 $200 of the total billed hospital charges.

Also, if it is determined upon review of your inpatient claim that your inpatient admission was not medically necessary, a full or partial retroactive denial of inpatient benefits could result.

2 - CONCURRENT REVIEW: (CARE COORDINATION)

If you or your spouse or child is hospitalized, the Third Party Administrator's Case Management Department will monitor progress through the **Concurrent Review (Care Coordination) Program.** Medical review specialists will work with your physician to monitor treatment needs. The goal of Concurrent Review (Care Coordination) 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.

3 - DISCHARGE PLANNING: (CARE COORDINATION)

If you, your spouse, or child needs special services after hospitalization, the Third Party Administrator's Care Coordination Unit nurses 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 Care Coordination 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.

4 - 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. The Care Coordination nurse from the Third Party Administrator will contact you and/or your physician. If you accept this service, the Care Coordination nurse 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 specialty hospital or home care services. The nurse from the Third Party Administrator and your physician will help you review these suggestions. Once a treatment plan is determined, the Third Party Administrator's staff will help implement it.

Through your discussions with the Third Party Administrator's Care Coordination 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, the Care Coordination Department can help you make the choices that are best for you.

5 - SECOND SURGICAL OPINION

If you or an enrolled dependent is scheduled for a surgical procedure, you may opt for a second opinion from a provider of your choice before undergoing elective, non-emergency surgery. The second opinion will provide you and your physician with additional information and possible alternatives to the recommended procedure. Any applicable co-payments or co-insurances will apply. 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.

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.

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

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 8:00 p.m.** Monday through Friday, except holidays.

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

- Enrollee ID Number (from Employee Benefit Card)
- Patient's name and date of birth

EAST END HEALTH PLAN

PART III

HOSPITALIZATION

&

RELATED EXPENSE COVERAGE

PART III
HOSPITALIZATION & RELATED EXPENSE COVERAGE

INPATIENT HOSPITAL CARE

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

Hospital: A hospital shall be an institution which meets all of the following requirements:

- It must be primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment, and care of injured or sick covered persons;

- It must have organized departments of medicine and surgery;

- It must have a requirement that every patient must be under the care of a physician or dentist;

- It must provide 24 hour nursing service by, or under the supervision of, a registered graduate nurse (R.N.);

- It is duly licensed by the state agency responsible for licensing such hospitals, if licensing is required;

- It is not, other than incidentally, a nursing home or an institution, or part of one, which is primarily a place of rest, a place primarily for the treatment of tuberculosis, mental or emotional disorders, a place for the aged, or the chemically dependent, neither is it a place for custodial care, nor is it operated primarily as a school; and

- It can also be an intermediate care facility which in itself is an institution that provides care and treatment of mental, psychoneurotic or personality disorders, or chemical dependence, through one or more specialized programs.

A hospital must also:

- Be staffed by registered graduate nurses and other mental health professionals;

- Provide for the clinical supervision of such specialized programs by physicians who are licensed in the state in which the facility is located; and

- Ensure that each specialized program provided by it must:

- Furnish a written individual treatment plan which states specific goals and objectives.

- Maintain at a minimum on-going weekly progress notes which demonstrate periodic review, and direct patient care by the attending physician.

A Hospital must also:

- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or

- Be licensed, accredited, or approved by the appropriate agency in the state in which it is located, to provide the type of specialized program described above.

In no event will the term "hospital" include a nursing home or an institution or part of one which:

- Is primarily a facility for convalescence, nursing, rest, or the aged;

- Furnishes primarily domiciliary or custodial care, including training in daily living routines; or

- Is operated primarily as a school.

The following are not considered hospitals: ambulatory surgical centers; freestanding diagnostic and treatment centers; nursing homes; skilled nursing facilities (SNFs); school, college, or camp infirmaries; rehabilitation facilities; and places mainly for the care and treatment of the aged, chemical dependence, mental disorders, and tuberculosis.

Partial Hospitalization is treatment in a hospital or other licensed facility for less than 24 hours but more than four hours in any one day.

As an admitted patient in a hospital as defined above, you and your enrolled dependents are each eligible to receive the following benefits:

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.

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.

COVERAGE:

The dollar values maximum benefits, co-payments and deductibles as well as the co-insurance percentages are all identified in the Benefit Summary Section at the beginning of the Plan Document. Certain benefits under the program may have different co-insurance/schedule of benefits and/or not be subject to deductibles as identified in the Benefit Summary.

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

Covered Hospital 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.

NOTE: If you use an out-of-network provider you are responsible for the charges billed and must submit a claim for benefits due. These benefits are calculated based on the deductible that you are responsible for, the co-insurance which is the set percentage of the reasonable and customary expenses, and any charges in excess of the reasonable and customary expenses that the provider may charge.

Inpatient Hospital Care: Each day of inpatient hospital care, or care in a birthing center, counts as one day of care toward the 365-benefit-day limit.

Inpatient Mental Health & Substance Abuse: Each day of inpatient facility care counts as one day of care toward the 365-benefit-day limit subject to the provisions of the Federal Mental Health and Substance Abuse Parity Act.

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.**

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.***

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.**

Skilled Nursing Facility Care: The Plan will provide up to 90 days of medically necessary care at a Skilled Nursing Facility.

Home Health Care: The Plan will provide up to 100 days of care of medically necessary home health care services.

Outpatient Hospital Care and Hospice Care: Outpatient hospital care is provided whenever you meet the requirements. The 365-benefit-day limitation does not apply to outpatient 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.

MATERNITY CARE:

Maternity benefits are provided for childbirth or miscarriage expenses incurred in a hospital for all enrollees in 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.

OUTPATIENT SERVICES

You will be required to pay a co-payment per visit for some of the outpatient 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 outpatient 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.**

- **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 one of the following conditions apply:

  - 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,
  - 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.

- **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.

- **Radiation Therapy.**

- **Laboratory Tests:** Benefits for the use of the in-network laboratory provider (see the Benefit Summary Section of this Plan Document for the name 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 outpatient department.

- **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 outpatient department.

- **Pre-surgical Testing:** Subject to a co-payment per visit. The following conditions must be met:

    - The tests are ordered by a physician as a preliminary step in your admission to a hospital as a registered bed patient for surgery; **AND**

    - They are necessary for, and consistent with, the diagnosis and treatment **of** the condition for which surgery is to be performed; **AND**

    - You have a reservation for the hospital bed and for the operating room before the tests are given; **AND**

    - You are physically present at the hospital when the tests are given; **AND**

    - Surgery actually takes place within **14** days after the tests are given.

- **Physical Therapy:** Benefits will be provided for physical therapy in an outpatient setting only when the treatments are ordered by your physician.

  Please note that physical therapy benefits are available under the major medical provisions of the plan also.

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

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

    - Oral chemotherapy; **OR**

- Subcutaneous injection; **OR**

- Intramuscular injection.

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

  - Upon the recommendation of a physician, at any age for covered enrollees who have a prior history of breast cancer or whose mother or sister has a prior history of breast cancer;

  - A single baseline mammogram for covered enrollees 35 through 39 years of age;

  - 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.

- **Bone Density Screening**

  The plan pays for bone mineral density measurements and tests for the detection of osteoporosis. The Plan will apply the standards and guidelines that are consistent with the criteria of the Federal Medicare program or the National Institute of Health (NIH) to determine appropriate coverage for bone density testing under this Section of the Plan Document. Coverage will be provided for tests covered under Medicare or consistent with NIH criteria including, as consistent with such criteria, dual-energy x-ray absorptiometry. When consistent with Medicare or NIH criteria, coverage, at a minimum, will be provided for those covered persons:

  - Previously diagnosed as having osteoporosis or having a family history of osteoporosis,

  - With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis,

  - On a prescribed drug regimen posing a significant risk of osteoporosis,

  - With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

  - With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

- **Outpatient Mental Health and Substance Abuse:** The Plan pays the medically necessary allowable amount for mental health and substance abuse services. These outpatient services are subject to a co-payment.

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

Each period of up to four (4) hours of home health aide will be considered one visit. The maximum benefit for home health care is limited to 100 visits per calendar year.

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.

Coverage is available in institutions that are approved as skilled nursing facilities by Medicare, or the Joint Commission on Accreditation of Hospitals.

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.

HOSPICE CARE

The Plan pays the allowable amount for the hospice care program if the covered person's primary attending doctor certifies that the covered person meets all of the following conditions:

- The covered person experiences an illness for which the attending physician's prognosis for life expectancy is estimated to be less than six months,
- Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate,
- The attending physician refers the covered person to the hospice care program and is in agreement with the plan for care of the condition,
- It is determined that hospice care is medically necessary; and
- The covered person is formally admitted to the hospice program.

Covered Benefits Include Only the Following:

- The confinement of a terminally ill patient as an inpatient in a hospice facility, and
- The hospice care furnished to the terminally ill patient, by the hospice provider, in the patient's home.

Limitations and/or exclusions. The following charges are not covered:

- Any charges incurred during a remission period are not covered. This applies if, during remission, the terminally ill person is discharged from the hospice care program.
- Services provided by the covered person, the covered person's close family.
- The maximum lifetime benefit for hospice care is 210 days.

WORLDWIDE PROTECTION

In a foreign country you may have to pay first for services you receive. Then if you are required to pay a bill for services provided covered under the Plan, submit the itemized bill along with a claim form to the Third Party Administrator and you will be reimbursed after deductible and coinsurance subject to currency exchange rates in place at the time the service was rendered.

Hospitalization benefits are provided anywhere in the world.

Inpatient Care: When you are admitted to any legally constituted general hospital, you receive

the benefits described in this booklet.

Outpatient 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.

EAST END HEALTH PLAN

PART IV

MAJOR MEDICAL EXPENSE BENEFITS (OUT-OF-NETWORK SERVICES)

&

PREFERRED PROVIDER PROGRAM (IN-NETWORK SERVICES)

PART IV

MAJOR MEDICAL EXPENSE (OUT-OF-NETWORK) BENEFITS & PREFERRED PROVIDER (IN-NETWORK) BENEFITS

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.

- **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.

- **Preferred Providers (**synonymous with In-network Providers) are those eligible providers who have agreed to accept payment directly from the Plan's Third Party Administrator (TPA), in accordance with the Schedule of Allowances, as payment-in-full for covered medical services under the Preferred Provider Program.

- **Schedule of Allowances** means the Plan's schedule, listing the amount it will pay to Preferred Providers for covered medical services.

- **A non-participating provider** is one who has not entered into an agreement with the Third Party Administrator (TPA) 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).

- **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.)

- **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.

- **Reasonable and Customary charge** means the lowest of:

  - The actual charge for a service or supply, **OR**
  - The usual charge by the physician or other provider for the same or similar service or supply, **OR**
  - 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.

- **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.

- **Calendar year** means the period beginning with January 1 and ending with December 31.

- **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.

- Under the Preferred Provider Program, the covered percentage is 100% of the Schedule of Allowances after the co-payment, except for accidental dental services, and durable

medical equipment which is 90% of the purchase 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:**

- As provided for outpatient psychiatric visits,
- As provided under the Managed Care Program for certain procedures, and
- 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 the out-of-pocket maximum expense in the calendar year. However, in calculating the co-insurance maximum, the annual deductible per individual accumulative maximum per family is not included.

- **Outpatient** 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,
- **Inpatient** means during confinement for which a room and board charge is made by a hospital or approved facility.
- The annual/lifetime maximum of the Major Medical portion of your medical expense benefits applies to you (the employee) and each member of your family separately. In-network benefits paid through the Preferred Provider Program do not count toward the annual maximum.

  A medical emergency 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.

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 Benefit Summary Section at the beginning of the Plan Document. Certain benefits under the program may have different co-insurance/schedule of benefits and/or not be subject to deductibles as identified in the Benefit Summary.

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.

- Preferred Providers (In-Network 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 review the benefits you received by logging on to the Third Party Administrator's website.

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

- 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 responsible for an annual deductible and for a percentage of covered medical expenses in excess of the deductible up to the out-of-pocket maximum and any amounts in excess of reasonable and customary charges. You may also assign the benefits under this program.

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

PREFERRED PROVIDER PROGRAM (IN-NETWORK PROVIDERS)

There is no cost to you for services or supplies when they are covered under the Preferred Provider Program, except for the co-payment where applicable. A Directory of all the Preferred Providers is available to you at the East End Health Plan Website (www.eehp.org) 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.

The following covered medical services are included in the Preferred Provider Program:

- **Office Visits:** You are covered for physicians' office visits by a physician for general medical care, diagnostic visits, treatment of illness, immunization visits, and well-baby care. General medical care includes routine pediatrics and physical exams.

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

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

- **Specialist Consultations:** Your physician may refer you to a specialist who 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.

- **Diagnostic Laboratory:** You are covered for diagnostic laboratory performed out of a hospital. If diagnostic laboratory and/or diagnostic radiology procedures are performed by a Preferred Provider during an office visit only **ONE** co-payment will apply.

- **X-Ray Examinations (X-Ray, MRI, CAT Scans, PET Scans):** You are covered for diagnostic 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 diagnostic laboratory and/or diagnostic radiology procedures are performed by a Preferred Provider during an office visit only **ONE** co-payment will apply.

- **Chiropractors:** You are covered for visits to your chiropractor and also for necessary related x-rays. **Maintenance care is NOT covered.** The extent of coverage may be determined by the Plan based on an ongoing review on a case-by-case basis.

- **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.

- **Podiatry:** You are covered for the services of a podiatrist except for routine care of the feet not related to diabetes subject to the plan limitations as listed in the Benefit Summary Section of this Plan Document.

- **Chemo/Radiation Therapy:** You are covered for radiation therapy given in or out of a hospital.

- **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 may be determined by the Plan based on an ongoing review on a case-by-case basis.

- **Routine Immunizations:** The cost of substances for **routine preventive immunizations** will be a covered expense.

- **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.). The lifetime total number of covered visits will be 7. No co-payment will be charged.

- **Infertility/Reproductive Benefit:** This benefit provides for Artificial Insemination and Assisted Reproductive Technology (dependent children are not eligible for this benefit) as follows:

  <u>Covered Services and Supplies:</u>
  - 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 five years.

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 $35,000 per individual.

Exclusions and Limitations

- Treatment of an individual who is able to achieve pregnancy, but is unable to carry 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 (e.g. 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 five years.
- Surrogate pregnancy.
- The reversal of voluntary sterilizations.
- Genetic screening and counseling.

- **Outpatient Mental Health & Substance Abuse Treatments:** You are covered for mental health and substance abuse for services provided by a physician or mental health provider licensed in the state where the services are rendered or by a certified registered social worker.

MAJOR MEDICAL EXPENSE PROGRAM
(OUT-OF-NETWORK PROVIDERS)

PRIOR TO OBTAINING ANY OF THE FOLLOWING SERVICES, you must contact the Third Party Administrator:

- Home Health Care
- Durable Medical Equipment (above $1,000)
- Hospice Care
- Oxygen/Respiratory Equipment
- Skilled Nursing Facility
- Accidental Dental
- Transplants
- Reconstructive Procedures

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.

If you use an out-of-network provider you are responsible for the charges billed and must submit a claim for benefits due. These benefits are calculated based on the deductible that you are responsible for, the co-insurance which is the set percentage of the reasonable and customary expenses, and any charges in excess of the reasonable and customary expenses that the provider may charge.

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.

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 (OUT-OF-NETWORK) 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:

- **Hospitals and Approved Facilities:**
    - Services of hospitals for which hospitalization benefits are provided are covered excluding:
        - Charges for room and board and special services provided to you as an in-patient during a period for which hospitalization benefits are provided;
        - Any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;
        - Charges for outpatient services covered by your hospitalization; **AND**
        - Services not billed for by the hospital.

    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 inpatient 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.

- **Physicians:** Services of physicians are covered including annual physical exams.
- **Nursing Services:** Services of a nurse are covered provided such services at home are:
    - Prescribed by a physician; AND
    - Rendered by a registered professional nurse (R.N.); or by a licensed practical nurse (L.P.N.) who must work for an approved agency or facility; AND
    - 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.

- **Nurse-Midwife Services:** Maternity services of a nurse-midwife are covered if the nurse-midwife is:

- Licensed or certified to practice nurse-midwifery;

- Permitted to perform the service under the laws of the state where the services are rendered.

- **Chiropractors:** Services of a duly licensed chiropractor will be covered for:

  - Manual manipulation of the spine to correct a subluxation that can be shown by X-ray;

  - Other services prescribed by a physician, **EXCEPT maintenance care**.

- **Acupuncturist:** Services of a licensed acupuncturist will be covered for the treatment of certain types of medical conditions when prescribed by a physician.

- **Podiatrists:** Services of duly licensed podiatrists for the treatment of:

  - Diseases
  - Injuries
  - Malformation of the foot

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

- **Routine Health Exams:** Routine health exams are covered up to a maximum reimbursement of $100 in a calendar year. These benefits are not subject to a deductible or co-insurance.

- **Routine Well Baby/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.

- **Hearing Aids:** Hearing aids, including examinations for and the fitting of, are covered up to a total maximum reimbursement of $1,500 per ear, once every four years. Children of the age 12 and under are covered up to a total maximum reimbursement of $1,500 per ear, once every two years. These benefits are not subject to deductible or co-insurance.

- **Durable Medical Equipment:** 80 percent of 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 once every three years. 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.

- **Prosthetics:** Artificial limbs or other prosthetic devices, including replacement when it is functionally necessary to do so, are covered once every three years.

- **Ambulance Service:** Charges for ambulance services are covered subject to a co-payment. Ambulance services are covered for emergency services only.

- **Voluntary Sterilization:** Charges for voluntary sterilization are covered medical expenses.

- **Miscellaneous Services:** The following services are covered under the Major Medical Program when not covered by your hospitalization plan:

    - Diagnostic lab procedures and x-rays or radiation treatments;
    - Oxygen and its administration;
    - Anesthetics and their administration;
    - Chemotherapy;
    - Hemodialysis.

- **Pre-Donation Of Blood:** The cost 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.

- **Orthotics:** Each claimant will be covered for only one orthotic claim during the calendar year. Charges will be reimbursed up to the limits described in the Benefit Summary Section of this Plan Document. These benefits are subject to the deductible and co-insurance of the Plan.

- **Physical Therapists:** Services of a duly licensed physical therapist will be covered when those services are prescribed by a physician.

- **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.

- **Mammography:** 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.

  Coverage will be available under these conditions:

  - 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;
  - A single baseline mammogram for covered persons 35 through 39 years of age;
  - 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.

- **Outpatient Mental Health & Substance Abuse Treatments:** You are covered for mental health and substance abuse for services provided by a physician or mental health provider licensed in the state where the services are rendered or by a certified registered social worker.

EXCLUSIONS and LIMITATIONS

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

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

- **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

  - Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment, or injury.
  - Not solely for your convenience or that of your doctor or other provider; and
  - 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:

  - That such service or confinement will be deemed to be medically necessary; or
  - 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:

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

- **Optical Services:** Payment will not be made for eyeglasses or contact lenses except as described in the Vision Care Benefits Section.

- **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.

  Cosmetic procedures and related services are 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.

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.

Reconstructive procedures are those 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.

- **Custodial Care:** Payment will not be made for custodial care. Care is considered custodial when it is primarily for the purpose of performing the activities of daily living 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 JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) approved skilled nursing facility for acute or skilled care which meets all contract guidelines and criteria.

- **Workers' Compensation:** Payment will not be made for care for any injury, condition, or disease if payment is available to you under a Workers' 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 Workers' 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 Workers' Compensation Law or similar legislation.

- **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.

- **War:** Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared.

- **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.

- **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.

- **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 Parts A & B and file for all benefits available to you under Medicare.**

- **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.

- **Experimental/Investigative Procedures:** Services or supplies, including any hospitalization, in connection with such technologies which are considered to be not medically necessary, experimental, investigative, obsolete, or ineffective.

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

  - Not of proven benefit for the particular diagnosis or treatment of the covered person's condition; or

  - 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.

  The Plan may apply any of the following criteria in determining whether a technology is not medically necessary, experimental, investigative, obsolete, or ineffective:

  - Any 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 drug or biological product for another diagnosis or condition may require that any of these criteria be met.

  - Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.

  - 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.

- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

- Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes (as defined in bullet 3 above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

- **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.

- Services or supplies for the administration of anesthesia if the charges for surgery are not covered under this Plan.

- Services or supplies to the extent they are not covered due to non-compliance with the requirements of the East End Health Plan for inpatient admission, Managed Care Program, inpatient diagnostic testing or other pre-authorization programs.

- Routine services which are duplicative because they are provided by both a nurse-midwife and physician.

- Services or supplies, including cutting or removal, for treatment of corns, calluses, or toenails, except care which is medically necessary due to metabolic disease diagnosed by a physician.

- 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.

- Services rendered for medical summaries and medical invoice preparations.

- Weight loss programs are not covered.

- Private Duty Nursing in the hospital setting is not covered.

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.

- **Plan** may include:
    - Any group insurance, or any other method of coverage for persons in a group.
    - An uninsured arrangement of group coverage.
    - Group coverage through HMOs and other prepayment, group practice and individual practice plans.
    - Any governmental plan, but not including a state plan under Medicaid.
    - 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.
    - The medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.
- **Plan** shall NOT include:
    - Blanket school accident coverage; or
    - 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 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.

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:

- If there are two plans which cover the same enrollees, the primary cardholder's plan is primary. For all other dependents coverage is as follows:

- 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 if said dates of birth are the same, the plan which has covered a person for the longest time will pay first.

  In this clause, 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:

  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with custody of the child;
  - 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.

- 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).

- If these 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:

- Two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

- 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 Third Party Administrator, without the consent of any person, will have the right 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.

- Recover any excess if the amount paid is more than it should have paid under this provision from one or more of:

    - The persons it has paid or for whom it has paid;
    - Insurance companies; or
    - 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 services, present your East End Health Plan Identification card.

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

The claim forms are then reviewed 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 provider/facility, a final review is made to determine the contract benefits available. The appropriate payment is made to the provider/facility.

HOW TO SUBMIT A CLAIM:

- If you go to a Preferred Provider, the Provider submits the claim directly to the Third Party Administrator. You are responsible for the co-pay.

- If you go to a non-preferred provider, refer to the instructions on the Health Claim Transmittal form for the specific items or information required. The claim form may be obtained from your District's Health Plan Coordinator, from the Third Party Administrator, or can be downloaded at the EEHP website (www.eehp.org).

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 "Medicare 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 Explanation of Benefits 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.

CLAIM INQUIRIES:

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

TERMINATION OF COVERAGE

Your coverage may terminate for any of the following reasons:

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

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

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:

- 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

- If the transfer is into the Plan, benefits are payable to the extent they are not paid through the former health insurance program.

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:

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

The Plan pays for medically necessary prescription drugs, syringes and needles as prescribed by a physician, in excess of any applicable co-payment up to the agreed upon in-network allowance that is determined by the Plan's prescription benefit administrator. The Plan pays for FDA approved brand name and generic medications subject to the co-payment structure that is identified in the Summary of Benefits Section at the beginning of the Plan Document.

The Plan has a **Mandatory Generic Drug Feature** that requires pharmacies to dispense generic drugs, which are widely accepted by the entire medical and pharmacy communities. Benefits will be provided as follows:

- If a pharmacy dispenses a generic drug, the member will pay the generic drug co-payment or the price of the drug, whichever is less.

- If the pharmacy dispenses a brand-name drug and there is a generic drug which can be substituted, but is not, then the member pays the brand name co-payment, and will be required to pay the difference between the cost of the generic drug and the brand-name drug.

- If no generic drug is available for substitution in place of a brand-name drug, the member pays the brand-name co-payment.

- If the member cannot tolerate the generic medication, they may contact the Prescription Benefit Manager (PBM) at the toll free number listed on the back of their prescription identification card and request a waiver of the Mandatory Generic Substitution Clause.

If you and your spouse are both enrolled in the East End Health Plan, the Plan provides a coordination of benefits provision for these coverages. Each spouse, as well as any dependents, needs to pay the designated co-payment when they have a prescription filled to either the retail or mail order pharmacy. Because of the dual enrollment in the East End Health Plan the enrollee may then submit a claim for the co-payments paid to the East End Health Plan. This claim must be submitted using a "Prescription Coordination of Rx Benefits" Form.

RETAIL PRESCRIPTION DRUG PROGRAM

At the participating pharmacy, there is a set co-payment for brand-name drugs, be they preferred, non-preferred, or generic drugs**.**

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 up to a 30-day supply and a co-payment for generic drugs via the mail order program for up to 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 the prescription benefit manager has classified as preferred, you will pay a co-payment at the retail pharmacy for up to a 30-day supply and co-payment via the mail order program for up to 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 prescription benefit manager. 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 prescription benefit manager has classified as non-preferred, you will pay a co-payment at the retail pharmacy for up to a 30-day supply and a co-payment via the mail order program for up to a 90-day supply. It is important to note that brand-name drugs that are classified as non-preferred generally have therapeutic equivalent brand-name drug included on the preferred drug list. Should you have a question concerning a specific brand-name drug, please contact the prescription benefit manager. 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 prescription benefit manager will reimburse you directly the same amount that would have been paid 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 up to a 30-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 ID 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, they should call the prescription benefit manager**.** Their phone number is included in the Contacts Section at the beginning of the Plan Document.

Prescription Drug Program Exclusions

Charges for the following services and/or supplies are NOT covered prescription drug expenses:

- Viagra and other impotency drugs in excess of 6 pills per insured per month.
- Vitamins. **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 support garments and other non-medicinal substances. Please note that coverage may be available under the Durable Medical Equipment benefit.
- Cosmetic drugs including, but not limited to, hair removal products and hair growth stimulants.
- Non-legend (over the counter) drugs other than insulin.
- Prescriptions which an eligible person is entitled to receive without charge from any Workers' 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 prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original script.
- Prescription Medications that are classified as Proton Pump Inhibitors including Omeprazole, Pantoprazole, Nexium, Aciphex, Prevacid, and Protonix.

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. If you have any questions, please call the prescription benefit manager**.** 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 a 90-day supply of maintenance drugs under the mail order plan. For forms to utilize the maintenance mail order prescription drug program, please contact your District's Health Plan Coordinator.

Certain prescription medicines that require very specific delivery, storage, and administration requirements are classified as Specialty Drugs. These medications are typically high cost, bio tech, self-injectable medications. Due to the unique nature of this classification, they are available only at a 30-day supply even if delivered to the enrollee through the mail. A separate co-pay applies to these drugs for each fill.

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.

- **Out-of-Network (Non-Participating Provider) 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.

SCHEDULE OF BENEFITS
Out-of-Network (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:	Allowable Expense
• Eye examination.	$30
• Single vision lenses with frame.	$30
• Bifocal lenses and frame.	$60
• Trifocal lenses and frame.	$110
• Contact lenses	$110
• Medically necessary contact lenses for the correction of Keratoconus	$225

- **In-Network (Participating Provider) 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 breakage warranty is provided for all eyeglasses completely supplied by the Plan.

  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
In-Network (Participating Provider) Benefits

Any frame from the special selection of designer frames displayed on the "Tower Collection" at a participating doctor's office is available under the Plan with no co-payment. If you select a frame other than those available through the Plan, a $45 wholesale allowance will be applied towards their cost. 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 under the Plan with no copayment for standard, soft, daily-wear disposable or planned replacement contact lenses or a $75 credit plus 15% discount off any overage towards other types of contact lenses from the provider's own supply. Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

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

- Plastic or glass single vision, bifocal or trifocal 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.

Item	Co-Payments
• Premier Frame	$25
• Progressive Addition Lenses - Standard	$50
• Progressive Addition Lenses - Premium	$90
• Blended Segment Lenses	$20
• PGX Single Vision Lenses	$20
• PGX Multifocal Lenses	$20
• Scratch Resistant Coating - Single Vision	$20
• Scratch Resistant Coating - Multifocal	$20
• Ultraviolet Coating	$12
• Polycarbonate Lenses	$30
• Polarized Lenses	$75
• High Index Lenses	$55
• Plastic Photosensitive Lenses	$65
• Anti Reflective Coating - Standard	$35
• Anti Reflective Coating - Premium	$48
• Anti Reflective Coating - Ultra	$60
• Intermediate Vision Lenses	$30

These co-pays are subject to change periodically. The most current co-pays can be found on the EEHP website (www.eehp.org).

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, there is no co-payment required. If you need to select contact lenses other than those available through the Plan, a $75 allowance plus 15% discount off overage will be applied towards 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.

Vision Program Exclusions

Charges for the following services and/or supplies are NOT covered vision expenses:

- 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 political 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.
- Charges for services due to occupational accidents or sickness covered by Workers' Compensation.
- More than one pair of lenses or examinations per person per 12 month period.
- Contact lenses for cosmetic purposes.
- Tinted glasses unless specifically prescribed because of medical or occupational reasons.
- Safety glasses or goggles.
- 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 processing of claims.

Claims must be submitted as indicated in the "How, When and Where to Submit Claims" Section of this document. However, at its sole discretion, the EEHP may accept a claim if extenuating circumstances prevented the member from making such a claim within the designated time frame.

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 such claim shall be wholly or partially denied, such notice shall be in writing and worded in a manner 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) an explanation of the scientific or clinical basis for medical necessity or experimental treatment denials; (d) 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 (e) an explanation of the Plan's claims appeal 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 appeal procedure.

Claim Appeal Procedure:

Level I

Within 180 days following receipt by the claimant of notice of the adverse determination, the claimant may appeal the adverse determination of the claim by filing a written request for review with the Third Party Administrator.

The request shall be made in writing and filed with the Third Party Administrator within 180 days after delivery to the claimant of written notice of the adverse determination. Such written request for review shall contain all additional information, which the claimant wishes the Third Party Administrator to consider. The request should include:

- The patient's name and the identification number from the ID Card.
- The date(s) of medical service(s).
- The provider's name
- The reason that the claimant believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

Following such request for review, the Third Party Administrator shall fully and fairly review the additional information. The review will be conducted by a qualified individual who was not involved in the decision being appealed. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Third Party Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The claimant, through the submission of their request, consents to this referral and the sharing of pertinent medical claim information. Upon the claimant's request and free of charge, the claimant has the right to reasonable access to (including copies of) all documents, records, and other information relevant to the claim for benefits.

The Third Party Administrator will render a decision on the request within sixty (60) days of receiving the request for review.

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.

Urgent Appeals that Require Immediate Action

If an appeal requires immediate action (if a delay in treatment could significantly increase the risk to the claimant's health or the ability to regain maximum function or cause severe pain), an expedited appeal can be requested of the Third Party Administrator. In these urgent situations the appeal does not need to be submitted in writing. The enrollee or the physician should contact the Third Party Administrator as soon as possible. The Third Party Administrator will provide the claimant with a written or electronic determination within 72 hours following receipt by the Third Party Administrator of the request for review of the determination taking into account the seriousness of the claimant's condition.

Level II – Review by the Trustees' Appeal Committee

The claimant who is dissatisfied with the Third Party Administrator's 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 60 days after receiving written denial of the claim or portion of the claim from the Third Party Administrator, as a result of the Level I review. An extension of the 60 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" addressed to the East End Health Plan, c/o Eastern Suffolk BOCES, 201 Sunrise Highway, Patchogue, NY 11772.

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, may seek outside professional medical consultation, and may require the 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 at the next regularly scheduled Board of Trustees' Meeting. The Third Party Administrator will be advised of the East End Health Plan's final decision. The EEHP 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 VIII

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.

- **Vested Employee** means you, the enrollee, who has elected to maintain coverage while in vested status and has satisfied the minimum requirements as set forth in this Plan document.

- 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.**

- **Retired Employees and/or Vested 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.

- **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. 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.

- **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.

- **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 East End Health Plan 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

PART IX
USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

- **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:

    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
    - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
        - resolution of internal grievances; an
        - 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.

- **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.

- **Adoption of Third Party Administrator's and Pharmacy Benefits Manager's 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

- **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.