Putnam/Northern Westchester Health Benefits Consortium

Plan Document

Form No. PNW-2010-01
(Effective April 1, 2010)

Important Phone Numbers and Addresses

Aetna – Medical and hospital claims administrator

Customer Service: 1-877-223-1685

To locate an Aetna participating provider:

http://www.aetna.com/docfind/index.html

or call Aetna's Customer Service phone number listed above

Medical and hospital claims should be mailed to:

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

Express Scripts – Prescription drug claims administrator

Customer Service: 1-866-790-8282

To locate an Express Scripts Pharmacy, or to view the formulary:

www.express-scripts.com

Paper claims should be mailed to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
Attn: Claims Department

Putnam/ Northern Westchester Health Benefits Consortium

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

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

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

District Benefits Representatives

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

New York State Insurance Department

Albany:	New York City:
Consumer Services Bureau NYS Insurance Department One Commerce Plaza Albany, NY 12257	Consumer Services Bureau NYS Insurance Department 25 Beaver Street New York, NY 10004-2319
518-474-6600 800-342-3736	212-480-6400 800-342-3736

PREFACE

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

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

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

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

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

Aetna Plan No.: ASC-100166 –Choice POS II
Express Scripts Plan No: PW2
Consortium Document Form No.: PNW-2010-01

PLAN DESCRIPTION

PUTNAM/NORTHERN WESTCHESTER
HEALTH BENEFITS CONSORTIUM

CONTENTS

SPECIAL NOTES

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

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

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

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

SCHEDULE OF BENEFITS

NOTE

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

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

HOSPITAL EXPENSE BENEFITS

Any overnight admission to a hospital or other facility shall be subject to a $200 deductible.

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a $75 deductible per day. All other hospital/ facility outpatient services shall be subject to a $25 deductible per day. The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.

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

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

Hospital Inpatient Services

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

- **In an In Network General Hospital:** 100% of allowable charges, after deductible(s),
- **In an Out of Network General Hospital**: 90% of allowable charges, after deductible(s),

Mental and Nervous Conditions: up to 31-days[#] of confinement, concurrent with the In-patient Psychiatric Services/ Treatment benefit under the Medical Expense Benefits portion of the Plan, for each calendar year in a general or public hospital (excludes Private Proprietary Hospital).

- **In an In Network facility**: 100% of allowable charges, after deductible(s).
- **In an Out of Network facility** : 90% of allowable charges, after deductible(s).

[#] The 31-day limit does not apply to services for the treatment of Biologically based mental illness or for Children with serious emotional disturbances. In such cases, the 365-day limit, noted previously shall apply.

When a Partial Hospitalization Therapy program is deemed to be in the best interest of the patient and the plan and, in the absence of such treatment, an inpatient admission would otherwise be necessary, such treatment shall be covered such that each visit for treatment shall reduce the remaining available inpatient coverage for Mental and Nervous Conditions under the Hospital portion of the Plan and the In-patient Psychiatric Services/ Treatment benefit under the Medical Expense Benefits portion of the Plan, concurrently one-half (1/2) day. Intensive Outpatient Day Therapy must be pre-certified under the Managed Benefits Program.

Chemical/substance/alcohol abuse or dependence: up to seven (7) weeks per person per calendar year while confined as a registered bed patient in an approved facility.

- **In an In Network facility** : 100%, of allowable charges, after deductible(s).
- **In an Out of Network facility**: 90% of allowable charges, after deductible(s).

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

- **In an In Network facility** : 100%, of allowable charges, after deductible(s).
- **In an Out of Network facility**: 90% of allowable charges, after deductible(s).

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

- **In an In Network facility:** 100% of allowable charges, after deductible(s).
- **In an Out of Network facility:** 90% of allowable charges, after deductible(s).

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

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

- **By an In Network provider/agency:** 100% of allowable charges, after deductible(s).
- **By an Out of Network provider/agency:** 90% of allowable charges, after deductible(s).

Birthing Center In Network:

- **In an In Network facility:** 100% of allowable charges, after deductible(s).
- **In an Out of Network facility:** 90% of allowable charges, after deductible(s).

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

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

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

Any overnight admission to a hospital or other facility shall be subject to a $200 deductible per stay.

HOSPITAL OUT-PATIENT/ SURGICAL CENTER SERVICES

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a $75 deductible per day. All other hospital/ facility outpatient services shall be subject to a $25 deductible per day. The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.

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

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

	surgical care; (3) the treatments begin no later than six (6) months from the date of discharge from the hospital or the date of surgery; (4) the treatments are billed by the hospital; and (5) the treatments are received within one year from the later of (a) date of discharge from the hospital or (b) the date of surgery; 90%, of allowable charges, after deductible(s), for Out-of-Network facilities.
Hemodialysis	100% of allowable charges, after deductible(s), at an In-Network facility; 90% of allowable charges, after deductible(s), at Out-of-Network facilities.
Emergency Hospital Ambulance Service	100% of allowable charges, after deductible(s), when ambulance services to, and/or from, the hospital are provided by a professional ambulance service which is owned, operated and billed for by an In-Network hospital; 90% of allowable charges, after deductible(s), for Out-of-Network hospitals.
Outpatient Chemical Dependence Services/Treatment	Limited to an aggregate maximum of sixty (60) visits per person, per calendar year; 100% of allowable charges, after deductible(s), of at an In-Network facility; 90% of allowable charges, after deductible(s), at Out-of-Network facilities. Twenty (20) of those visits may be used for family therapy.

Hospital emergency room visits and outpatient hospital/ facility surgical services shall be subject to a $75 deductible per day. All other hospital/ facility outpatient services shall be subject to a $25 deductible per day. The Emergency Room co-payment shall be waived if the patient is directly admitted for an overnight stay.

MEDICAL EXPENSE BENEFITS

Annual Deductible

Per Person	$ 500 per calendar year
Maximum per Family	$ 1,500 per calendar year

Coinsurance/Copayments/Out-Of-Pocket

For eligible services of Preferred Providers, the member is responsible for a CO-PAYMENT of
$20 per visit for Primary Care providers;
$25 per visit for Specialists and Urgent Care Facilities; and
$20 for all laboratory services performed per day per provider; and
$20 for all radiology services performed per day per provider.
The member is not responsible for meeting the deductible or coinsurance.
The co-payment is not credited towards the deductibles.
The co-payment is credited towards the maximum out of pocket amount.

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

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

When the combined aggregate of a member's co-payments and coinsurance, referred to as Out of Pocket, (individual or family) for the calendar year equals **$2,789****, further co-payments and coinsurance are waived for the remainder of the calendar year.
****Excludes prescription drug and in-network hospital co-payments /coinsurance/ deductibles.**

The Out of Pocket amount will be indexed for 2011, and subsequent years, as specified in the chapter entitled "Medical Expense Benefits".

Wellness Services	Refer to Medical Expense Benefits section for details.
Non-Hospital Private Duty Nursing	80% of allowable charges up to a maximum payment of $400 per day.

Outpatient Psychiatric Services/	Maximum of 40 visits per person per calendar year, unless such services are for the treatment of biologically based mental illness or children with serious emotional disturbances; subject to copayments, coinsurance and deductibles.
Inpatient Psychiatric Services/ Treatment	31 days per person per calendar year, concurrent with the Mental and Nervous Conditions benefit under the Hospital Expense Benefits portion of the Plan. When an Intensive Outpatient Day Therapy program is deemed to be in the best interest of the patient and the plan and, in the absence of such treatment, an inpatient admission would otherwise be necessary, such treatment shall be covered such that each day of treatment shall reduce the remaining available inpatient coverage for Mental and Nervous Conditions under the Hospital portion of the Plan and the In-patient Psychiatric Services/ Treatment benefit under the Medical Expense Benefits portion of the Plan, concurrently, one-half (1/2) day. Intensive Outpatient Day Therapy must be pre-certified under the Managed Benefits Program.

PRESCRIPTION DRUG EXPENSE BENEFITS

Pharmacy Co-payment

$10 for Generic Drugs;
$25 for preferred Non-Generic Drugs;
$40 for non-preferred drugs.

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

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

The Consortium utilizes Express Scripts to administer a home delivery prescription drug program for maintenance, or long-term use drugs. Special provisions exist for the use of the Mail Order Pharmacy. Mail Order Kits can be obtained from the employee's School District business or personnel office.

Co-payments are limited to an aggregate maximum of **$1,000 per individual or family per year**.

ELIGIBILITY

WAITING PERIOD

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

OPEN ENROLLMENT PERIOD

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

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

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

EMPLOYEE ELIGIBILITY

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

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

DEPENDENT ELIGIBILITY

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

A. Spouse means an individual to whom the employee is legally married in accordance with the laws of the state of residence; same-sex only domestic partners may be covered. Please refer to Appendix C for the Plan's domestic partner policy

B. An unmarried child under 19 years of age must be dependent upon his parent(s) for at least 50% of the child's support and maintenance.

C. An unmarried child 19 years of age or older but under 25 years of age and who is a full time student at an accredited secondary or preparatory school, college, university or other educational institution must be dependent upon his parent(s) for at least 50% or more of the child's support and maintenance.

Time spent in service with a branch of the United States military, not to exceed 4 years, may be deducted from the age of a student dependent in determining his eligibility for enrollment.

D. With the exception of an employee's natural born children, adoptive children, proposed adoptive children or stepchildren, the dependent must reside permanently in the employee's home. Residence of a temporary nature or limited duration, as in the case of an exchange student, is not sufficient to provide eligibility for coverage.

E. An enrolled dependent child who reaches age 19 and whose birthday occurs during the summer vacation following graduation from high school shall continue to be covered if it is anticipated that he will be enrolled in an accredited educational institution as a full-time student at the end of the vacation period.

F. A handicapped child as defined under "Dependent" in the "Definitions" section.

G. Any person who does not specifically meet one of the criteria outlined in this section shall not be an eligible dependent.

H. Any person who is on active duty in the armed forces of any country shall not be an eligible dependent

DECLINATION OF HEALTH BENEFITS

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

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

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

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

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

Coverage must be applied for within 30 days of termination.

EMPLOYEE COVERAGE

If an employee applies for enrollment within one month of the date of FIRST eligibility, the employee's coverage may become effective on the first day of the month following the month in which the employee applies for coverage.

A. If an employee requests that coverage begin on the first date of employment, the employer may, at its discretion, comply with the employee's request provided the employee applies for coverage on or before the date of employment.

B. The participating employer may, at its discretion, also require the employee to satisfy a period of employment before coverage for the employee and any eligible dependents becomes effective;

however, this employment period must be applied on a uniform basis for all new employees and may not exceed six months. The effective date of coverage will be the first day of the month following the month during which the employee satisfies the required period of employment. An employee who is hired on, or otherwise acquires eligibility on, the first day of a month may count that month in establishing his effective date of coverage.

An employee who fails to apply for enrollment during the one month period following the date of his first eligibility must then wait for the annual enrollment period to apply for coverage.

DEPENDENT COVERAGE

A. If an employee applies for Family coverage at the same time as Individual coverage, the effective date of Family coverage will be the same as the employee's.

B. If an employee applies for Family coverage within 31 days of the date an eligible dependent is first acquired; the effective date of Family coverage will be the first day of the month following the month in which Family coverage is requested. If the request is made on the first day of the month and is within 31 days of acquiring the dependent, then coverage may become effective that day.

1. If this change is due to marriage and the employee requests that Family coverage begins on the date of marriage, the employer may comply with the employee's request provided application is made on or before the date of marriage.

2. If this change is due to the birth or adoption of a child and the employee requests that Family coverage begins on the date of birth or adoption, the employer shall comply with the employee's request provided application is made within 31 days of the date of birth or adoption.

C. If an employee who has only Individual coverage requests a change to Family coverage more than 31 days after the acquisition of an eligible dependent, then the employee must wait until the annual enrollment period to apply for Family coverage; however, if the new dependent is a newborn infant, then coverage shall become effective from the date the employer is notified of the birth or adoption.

D. If an employee who has family coverage requests to add an additional dependent more than 31 days after acquisition of the new dependent, coverage shall become effective no earlier than the first day of the calendar month following the month in which the request is made; however, if the new dependent is a newborn infant, then coverage shall become effective from the date the employer is notified of the birth or adoption

LOSS OF ELIGIBILITY BY STUDENT DEPENDENTS

A. In the event of a student’s graduation, coverage will be terminated on the last day of the month in which graduation takes place.

B. In the event of a student dependent’s marriage, coverage will cease on the date of marriage. Please refer to the section titled, “Continuation of Coverage (COBRA) and Extended Benefits”.

C. In the event that a student loses eligibility because of his parent’s loss of eligibility, the student’s coverage will cease at the time the parent’s coverage ceases. Please refer to the section titled, “Continuation of Coverage (COBRA) and Extended Benefits”.

D. In the event that a student (without military service) attains age 25, his coverage shall cease on the last day of the month in which he reaches age 25. Please refer to the section titled, “Continuation of Coverage (COBRA) and Extended Benefits”.

In the event that a student has had his eligibility extended by virtue of military service, coverage will cease on the last day of such extension unless eligibility ceases at an earlier date for one of the above reasons.

E. Medical Leave of Absence: In the event that a student is granted a medical leave by his educational institution, coverage may be extended for a maximum of one (1) year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. The Consortium must be notified within sixty (60) days of the leave commencing. Adequate documentation shall be required.

F. If a student drops out midterm for any reason other than a medical leave of absence, coverage shall cease on the date of withdrawal from classes. Please refer to the section titled, “Continuation of Coverage (COBRA) and Extended Benefits”.

CHANGES FROM FAMILY COVERAGE

A. An enrollee may change from Family coverage to Individual coverage at any time. Adjustment of the employer’s and employee's contribution toward the cost of coverage shall not take effect until the first day of the month following the month of the request to change to Individual coverage.

B. If, and only if, the sole dependent of an enrollee is also an eligible employee or retiree of a participating employer, but not already covered as an employee or retiree, Family coverage may be changed to two Individual coverages. This coverage change shall take effect on the first day of the month following the month of the change request.

C. If the spouse of an employee enrolled for Family coverage is also an employee or retiree of a participating employer, but not already covered as an employee or retiree, enrollment may be transferred from the currently enrolled spouse to the dependent spouse only during the annual, open enrollment period.

RETIREMENT

A. An employee or retiree of a participating employer is eligible to continue coverage in retirement if he:

1. has had at least ten (10) years of full-time service, not necessarily continuous, with the employer from which he is retiring; (In the event that an employer’s collective bargaining agreement, internal policy or past practice differs from 10-years, it shall take precedence over this provision of the Plan Document).

2. has vested for benefits from a retirement system administered by the State of New York; and

3. is at least 55 years of age.

B. An employee or retiree is also eligible to continue coverage during retirement, regardless of age or length of service with the participating employer, if granted a service connected disability retirement by a retirement or pension plan or system administered and operated by the State of New York due to an injury, illness or disease that resulted from his service with the participating employer.

C. Employees who have qualified for Social Security Disability payments are considered to be retired for health benefits purposes, regardless of age, provided that they have had at least 10 years of service with the participating employer. Proof of Social Security status will be required.

DEATH OF ENROLLEE - SURVIVOR COVERAGE

A. In the event of the death of an employee or retiree enrolled for Individual coverage, coverage will terminate on the date of death.

B. In the event of the death of an employee or retiree enrolled for Family coverage, the coverage of any surviving dependents must be continued in accordance with the Federal COBRA continuation coverage rules. The employer shall make a contribution toward the cost of this coverage, for a period of at least 3 months, at the same percentage the employer had been making immediately preceding the death of the employee. After 3 months, the full cost of coverage shall be paid by the surviving spouse or dependents, unless the participating employer establishes administratively or through contract negotiations, a contribution less than 100% for surviving spouses and/or dependents.

1. If the deceased employee or retiree was enrolled for Family coverage and had completed ten (10) years of active service or as an employee having had completed the years of service required to become eligible for vesting in the Teachers' Retirement System or Employees' Retirement System prior to death, then the spouse of the deceased employee may continue coverage as long as the spouse remains unmarried and dependent children may continue coverage for as long as the children would have been eligible had the enrollee lived. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share). A participating employer may choose to reduce the above ten (10) year requirement. In addition, a participating employer may share in the cost of the surviving spouse's and/or dependent's coverage.

2. Regardless of the length of service, if the death of an active employee enrolled for Family coverage results from a work incurred injury, the surviving dependents may be eligible to continue coverage as dependent survivors. To be eligible, the survivors must be entitled to accidental death benefits payable by a retirement system or pension plan administered by the state or civil division thereof, or to death benefits provided under the Worker's Compensation law. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share).

C. To enroll as a surviving dependent or spouse, the spouse or dependent must inform the business or personnel office of the applicable employer within 90 days of the employee's death. No application made after the 90 day period will be accepted. Since application must be made while coverage is still in effect, the dependent survivor(s) will retain the enrollee's original effective date of coverage.

D. The survivor(s) will be issued new identification cards containing the name of the surviving spouse. If there is no spouse and only dependent children are being enrolled, the name of the oldest child will be entered on the card.

E. When the dependent survivors are required to pay the full cost of coverage and only one or two survivors are eligible to continue health benefits, one or two Individual enrollments can be established rather than a Family enrollment. If there are three or more survivors and a Family enrollment is established, a change to two Individual enrollments can be subsequently established at any time if only two of these survivors continue to be eligible.

VESTING FOR BENEFITS

A. Employees who terminate their employment before age (55) may continue their health benefits if they have;

1. satisfied the minimum requirements established by their retirement system for vesting receipt of their retirement allowance (this need not be done officially);

and

2. met the minimum requirements of the employer, other than age, for continuation of health benefits into retirement;

and

3. terminated employment within five (5) years of the date on which they (a) are entitled to receive a retirement allowance or (b) become age fifty five (55).

B. Eligible employees who wish to continue coverage as enrollees in the program during vested status, must pay both the employer and employee share of the cost of coverage (i.e. the full cost of coverage) from the date their employment terminates until the date they become eligible to receive a retirement allowance from an approved retirement system. After that date, they are only responsible for the retiree's share of payments, if any. All required payments by vestees must be made to the employer where they were formerly employed.

C. Vestees, who wish to continue coverage into their retirement, must continue health insurance coverage as an enrollee or as a dependent of an enrollee while in vested status. This may include coverage as the spouse of an enrollee of a participating employer different than that of the vestee. Further, if the vestee maintains continuity of coverage as a dependent of an enrollee, he may continue vestee status beyond that date that he initially becomes eligible to receive a retirement allowance from an approved retirement system. **A vestee whose coverage lapses will not be permitted to reinstate coverage, either during vested status or after retirement.**

D. Once an employee has established eligibility to continue health benefits coverage as a vestee through one participating employer, that eligibility shall not be impaired by subsequent employment and/or enrollment through another participating employer, except when the employee establishes eligibility for coverage as a vestee or retiree through the second, or subsequent employer.

HOW TO USE YOUR BENEFITS

WHEN TO FILE A CLAIM

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

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

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

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

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

AETNA, Inc.
P. O. Box 981109
El Paso, TX 79998-1109
1-877-223-1685

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

2. Please review the claim form carefully and follow the instructions it contains.

OTHER GROUP COVERAGE

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

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

LATE SUBMISSION OF CLAIM

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

INCOMPLETE CLAIM FORMS

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

ASSIGNMENT OF BENEFITS

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

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

LEGAL ACTION

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

PHYSICAL EXAMINATIONS

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

This will be done at no cost to you.

IMPORTANT NOTE

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

DEFINITIONS

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

ADMINISTRATOR (PLAN)

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

ALLOWABLE CHARGES

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

AMBULANCE/LOCAL AMBULANCE

Professional ambulance service to the closest hospital or place of service.

AMBULATORY CARE CENTER

Any public or private establishment with:

a. an organized medical staff of Physicians;

b. permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

c. continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

d. which does not provide services or other accommodations for patients to stay overnight.

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

BIRTH(ING) CENTER

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

a. is operating primarily as a facility for the delivery of children following a normal, uncomplicated pregnancy;

b. is operating under the direct, full-time supervision of a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or a Registered Nurse (R.N.);

c. is equipped to perform routine diagnostic laboratory tests, and to handle medical emergencies;

d. maintains adequate, written medical records for each patient; and

e. has a written agreement with at least one local hospital for immediate acceptance of patients who develop complications or require hospital confinement.

CALENDAR YEAR

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

CHEMICAL DEPENDENCE

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

CHEMICAL DEPENDENCE TREATMENT FACILITY

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

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

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

COMPANION

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

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

CONVALESCENT NURSING HOME/
EXTENDED CARE FACILITY/
SKILLED NURSING FACILITY

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

a. maintains permanent and full-time facilities for bed care of 10 or more resident patients;

b. has available at all times the services of a Physician;

c. has a Registered Nurse (R.N.) or Physician on full-time duty in charge of patient care and one or more Registered Nurses (R.N.s), Licensed Vocational Nurses (L.V.N.s) or Licensed Practical Nurses (L.P.N.s) on duty at all times;

d. maintains a daily medical record for each patient;

e. is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injuries, and is not, other than incidentally, a rest home or a home for custodial care for the aged; and

f. is operating lawfully as a nursing home or extended care facility in the jurisdiction where it is located; in no event, however, shall such term include an institution primarily engaged in the care and treatment of chemical dependence.

COINSURANCE/CO-PAYMENT

The percentage or amount of charges payable by the member.

COVERED EXPENSE/COVERED CHARGE

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

COVERED PERSON

An individual enrolled and eligible for benefits under this Plan.

CUSTODIAL CARE

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

DEPENDENT

a. The covered spouse of an Employee and covered children between the ages of birth and 19 years provided such children are unmarried and dependent upon their parent(s) for support and maintenance. The term “children” shall include: natural children; legally adopted children; step-children. The term “children” shall also include any other children if the Employee provides support and maintenance and claims them as dependents in accordance with section 152 of the Internal Revenue Code. Proof of dependency may be required.

b. A covered dependent child after his 19th birthday provided the child is a full-time student (as determined by the educational institution) at an accredited secondary or preparatory school, college or university, or other accredited educational institution, dependent on his parent(s) for at least 50% support and maintenance and is under the age of 25. A covered dependent child whose 19th birthday occurs during school vacation period shall continue to be considered a covered Dependent under the Plan, provided the child is enrolled in an accredited educational institution as specified above and it is anticipated that the child will resume full-time student status at the end of the vacation period.

c. A covered dependent child is also an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap, and chiefly dependent upon the employee for support and maintenance, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. Proof of such incapacity and dependency must be furnished to the Plan by the Covered Person within 31 days of the termination age. If a dependent child is 19 or older at the time of initial enrollment, and that child was incapable of self-sustaining enrollment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap before the age at which coverage would otherwise terminate, such proof as required by the Plan must be submitted within 31 days of the initial effective date of coverage. The Administrator may require, at reasonable intervals, subsequent proof of the child's disability and dependency.

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

1. a spouse divorced from the Employee;

2. any person(s) while on active duty in any military service of any country.

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

DISABILITY/PERIOD OF DISABILITY

Any period of illness or injury, or multiple illnesses or injuries arising from the same cause, including any and all complications therefrom, which are not separated by complete recovery as certified by the attending Physician and return to active full-time employment in the case of the Employee; or in the case of a Dependent, return to the resumption of the normal activities of a person of the same age and sex in good health. For the purpose of renewing in-patient hospital and/or convalescent nursing home/extended care

facility/skilled nursing facility benefits, a new period of disability shall begin when the Covered Person has not been confined in such a facility for at least 90 days.

DURABLE MEDICAL EQUIPMENT

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

EMERGENCY ADMISSION

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

EMERGENCY CARE

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

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

EMERGENCY CONDITION

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

EMPLOYER/PARTICIPATING EMPLOYER

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

EXPERIMENTAL/INVESTIGATIVE AND/OR NON-CONVENTIONAL DRUGS, DEVICES, PROCEDURE, SURGERY, THERAPY OR TREATMENTS

A drug, device or medical/surgical therapy, treatment or procedure which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and which has not received the approval of the FDA, even when such drug, device or medical/surgical therapy, treatment or procedure is recommended by a medical professional: or a drug, device or medical/surgical therapy, treatment or procedure which has not been approved for payment by the U.S. Health Care Financing Administration (HCFA) in its directives to its claims

payers for their administration of the Federal Medicare Program, even when such drug, device or medical/surgical therapy, treatment or procedure is recommended by a medical professional.

FORMULARY

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

GENDER PRONOUNS

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

GENERIC DRUG

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

HOME HEALTH AIDE

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE PLAN

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

HOSPICE

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

HOSPICE CARE/PROGRAM

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

HOSPITAL

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

(1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
(2) Has organized departments of medicine and major surgery;
(3) Has a requirement that every patient must be under the care of a physician or dentist;
(4) Provides 24-hour nursing service by or under the supervision of a registered professional nurse (RN);
(5) If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Laws 89-97(42 USCA 1395x(k));
(6) Is duly licensed by the agency responsible for licensing such hospitals; and
(7) Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.

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

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

ILLNESS/ACTIVE ILLNESS

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

INCURRED DATE

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

INJURY

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

IN-PATIENT/IN-PATIENT CARE

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

INTENSIVE/CORONARY/ACUTE CARE CHARGE

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

MANAGED BENEFITS PROGRAM

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

MANAGED BENEFITS PROGRAM COORDINATOR

AETNA, Inc.
1-877-223-1685

MEDICALLY NECESSARY/
MEDICALLY NECESSARY CARE

Care which is:

a. consistent with the symptoms or diagnosis and treatment of a condition, disease, ailment or injury; and

b. in accordance with generally accepted medical practices; and

c. not solely for convenience of the Covered Person, Physician or other service provider, and

d. the most appropriate supply or level of service which can be safely provided.

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

MEDICARE

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

OUT-PATIENT/OUT-PATIENT CARE

A Covered Person shall be considered to be an "Out Patient' if treated in a hospital on a basis other than as a registered bed patient. Out-patient care includes services, supplies and medicines provided and used at a hospital under the direction of a Physician to a person not admitted as a registered bed patient. Out-patient care shall also include covered services rendered in the Physician's office, laboratory or X-ray facility, ambulatory care center or free-standing surgical facility, or the patient's home.

PHYSICIAN

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

PLAN NAME

The name of the Plan is the

PUTNAM/NORTHERN WESTCHESTER HEALTH BENEFITS CONSORTIUM HEALTH PLAN.

The Plan currently utilizes AETNA's Choice POS II option.

PREFERRED PHYSICIAN/PROVIDER

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

PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

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

PSYCHIATRIC SERVICES/TREATMENT

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

REHABILITATION FACILITY

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

a. has a transfer agreement with one or more hospitals;

b. is primarily engaged in providing comprehensive, multi-disciplinary physical restorative services, post-acute hospital and rehabilitative in-patient care; and

c. is duly licensed by the appropriate government agency to provide such services.

A rehabilitation facility shall not include an institution which provides only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis, unless such facility is licensed, certified or approved as a rehabilitation facility for the treatment of medical conditions or chemical dependence in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for Accreditation of Rehabilitation Facilities.

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

ROOM AND BOARD CHARGES

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

SEMI-PRIVATE CHARGE

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

USUAL, REASONABLE AND CUSTOMARY CHARGES (URC)

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

WAITING PERIOD

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

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

CONTINUATION OF COVERAGE

* VERY IMPORTANT NOTICE *

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

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

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

1. the death of your spouse;

2. a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. your divorce or legal separation from your spouse.

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

1. the death of a parent;

2. the termination of a parent’s employment (for reasons other than gross misconduct) or reduction in parent’s hours of employment with the Employer;

3. the parents divorce or legal separation; or

4. the dependent ceases to be a "dependent child" under the Plan.

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

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

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

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years (in most cases) unless you lost group health coverage because of a termination in employment or reduction in hours. In that case, the required continuation coverage period (normally) is 18 months. If, during that 18 months, another event takes place that also entitles you to coverage, coverage may be extended. Generally, the total amount of continued coverage may not be more than 36 months.

Note: Any beneficiary who was totally disabled within 60 days of the Employee's termination or reduction of hours and who qualifies (within the continuation period applicable to the original qualifying event) as "disabled" for Social Security purposes (provided the Plan Administrator is notified within 60 days of the determination by the Social Security Administration of such disablement), may (by paying an extra premium equal to 150% of the basic group rate for the extended time) have continuation coverage extended for all qualified beneficiaries from 18 months up to 29 months.

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

1 . the Employer no longer provides group health coverage to any of its Employees;

2. the premium for your contribution coverage is not paid within the required period; or

3. the individual becomes covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such individual; or

4. the individual becomes entitled (that is, covered) under Medicare.

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

American Recovery and Reinvestment Act of 2009 (ARRA)

Under ARRA, as amended, certain members whose employment is involuntarily terminated may be eligible for a COBRA premium subsidy of 65%. The termination and eligibility for COBRA must have occurred during the period September 1, 2008 through February 28, 2010. If you believe that you might be eligible for the COBRA premium subsidy, contact your district's benefits representative.

New York State Insurance Law

COBRA Extension to 36-months

If the continuation coverage you are eligible for under federal COBRA rules is for a period of less than 36-months, the coverage may be extended to a combined total of 36-months under NY State Law.

Coverage for Children Through Age 29

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

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

- inform the employer's benefits office, in writing, within sixty(60)-days following the date coverage would otherwise terminate due to age or no longer meeting the eligibility criteria; or
- Within sixty (60)-days after meeting the requirements for dependent status when coverage for the dependent child previously terminated; or
- During an annual thirty (30)-day open enrollment period (November 1-30 with following January 1 effective date); or
- During an initial 12-month prospective election period (January 1, 2010-December 31, 2010).

Extended Benefits

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

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

In addition to your rights under COBRA, you may be eligible to convert to a personal medical policy through AETNA. You may call AETNA for more information.

Supplementary Conversion and Continuation Rights for Military members

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

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

MANAGED BENEFITS PROGRAM

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

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

ADMISSION AND REVIEW PROGRAM

- **Elective Admission to a Hospital or Skilled Nursing Facility:** At least five working days prior to a scheduled non-emergency, elective in-patient hospitalization or admission to a Skilled Nursing Facility. Most psychiatric and chemical dependence admissions are planned and therefore require authorization at least five days prior to the admission.

- **Emergency Hospital Admission:** Within 48 hours of an emergency or maternity hospitalization.

- **Home Health Care Services, Private Duty Nursing or Hospice Care:** At least five working days prior to commencement of Home Health Care services, Private Duty Nursing or Hospice care.

- **Elective admission to a facility specializing in psychiatric, mental/nervous conditions or substance abuse, as an inpatient or patient in an intensive outpatient day therapy program:**
  At least five working days prior to a scheduled admission.

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

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

CONCURRENT REVIEW PROGRAM

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

What happens when you call?

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

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

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

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

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

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

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

Please Remember….

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

PHYSICAL EXAMINATIONS

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

LARGE CASE MANAGEMENT PROGRAM

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

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

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

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

NATIONAL MEDICAL EXCELLENCE PROGRAM (NME)

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

TRAVEL EXPENSES

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

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

LODGING EXPENSES

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

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

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

- while traveling with an NME Patient between the NME Patient's home and the Medical Facility to receive services in connection with any listed procedure or treatment; or

- when the Companion's presence is required to enable an NME Patient to receive such services from the Medical Facility on an inpatient or outpatient basis.

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

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

TRAVEL AND LODGING BENEFIT MAXIMUM

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

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.

- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

  one year after the day the procedure is performed; and
  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

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

LIMITATIONS

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

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

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

HOSPITAL EXPENSE BENEFITS

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

IN-PATIENT HOSPITAL CHARGES (GENERAL HOSPITALS)

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

a. *Room and Board - General Nursing Care:* The Plan shall pay the Semi-Private or Intensive/Coronary/Acute Care Charge for a Covered Person who is confined on an inpatient basis for the treatment of an illness or injury not to exceed the amounts indicated in the Schedule of Benefits. (The allowance for a private room shall be an amount equal to the hospital's most common semi-private room rate.)

b. *Hospital Miscellaneous Charges:* The Plan shall pay the usual, reasonable and customary amounts charged by the hospital for necessary services, medicines, blood (if not replaced) and plasma, and supplies for diagnosis and treatment of the illness or injury for which the Covered Person is confined (except services of a Physician, Dentist, special nursing in any form, or drugs or supplies not consumed or used in the hospital). Hospital Miscellaneous Charges shall be payable for all days of hospitalization for which the hospital's room and board charges are payable.

c. *Charges by a birthing center* shall be considered eligible charges to the extent such charges would have been covered if provided by a hospital as part of an in-patient confinement.

d. Coverage is provided for such period as is determined by the attending physician in consultation with the patient to be medically appropriate after such person has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy.

SKILLED NURSING FACILITY

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

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

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

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

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

a. accredited as a skilled nursing facility by the Joint Commission on Accreditation of Hospitals; or

b. certified as a participating skilled nursing facility under Medicare.

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

a. a semi-private room (if a private room is occupied, the Plan will pay an amount equal to the facility's most common charge for a semi-private room);

b. physical, occupational and speech therapy;

c. medical social services;

d. drugs, biologicals, supplies, appliances and equipment furnished for use in the facility and which are ordinarily provided by the facility to patients; and

e. other services necessary for the patient's health which are generally provided by the facility.

OUT-PATIENT HOSPITAL/SURGICAL CENTER CHARGES

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

a. *Emergency condition:* Benefits are payable for outpatient or emergency room charges (Physician's charges are covered under the Medical Expense Benefits portion of the Plan) for care given by a professional provider in or outside of a hospital for an emergency condition.

b. *Surgery and Radiation Therapy*: Benefits are payable for out-patient hospital charges (excluding Physician charges) related to the performance of a surgical operation or radiation therapy.

c. *Diagnostic X-Rays and Laboratory Charges:* Benefits are payable for out-patient hospital charges (excluding Physician charges) for diagnostic X-ray examinations and laboratory tests, including such examinations and tests performed as part of pre-admission testing for a proposed, covered hospitalization.

d. *Pre-Admission Testing:* Hospital services for pre-admission testing in the out-patient department of a hospital are covered, when:

- the testing is ordered by a Physician as a planned preliminary to the patient's admission as a registered bed patient for surgery in the same hospital;

- the testing is necessary for, and consistent with, the diagnosis and treatment of the condition for which the surgery is to be performed;

- the reservations for a hospital bed and an operating room have been made before the tests are performed; and

- the patient is physically present at the hospital for the tests.

e. *Physical Therapy:* Benefits are payable for physical therapy performed in the out-patient department of a hospital and billed by the hospital, provided: such therapy is in connection with a condition which necessitated hospitalization or surgery; treatment begins within six months from the date of the hospital discharge or surgery; and treatment is received within one year of the hospital discharge or surgery.

f. *Hemodialysis Treatment:* Benefits are payable for hemodialysis treatment performed in the out-patient department of a hospital and billed by the hospital.

EMERGENCY HOSPITAL AMBULANCE SERVICE

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

HOME HEALTH CARE

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

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

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

a. If the patient did not receive home health care visits, the patient would have to be hospitalized in a hospital or cared for in a skilled nursing facility. In other words, the home health care visits are a substitution for hospital care or care in a skilled nursing facility.

b. A Plan for the patient's home health care is established in writing, ordered or approved by the patient's Physician.

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

a. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.).

b. Part-time or intermittent home health aide services which consist primarily of caring for the patient.

c. Physical, occupational and speech therapy if the home care agency or hospital provides those services.

d. Medical supplies, drugs and medications prescribed by a Physician, but only if the Plan would have paid for those items if the patient was in a hospital or confined in a skilled nursing facility.

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

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

HOSPICE CARE

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

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

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

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

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

CHEMICAL DEPENDENCE TREATMENT BENEFIT

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

Out-patient treatment by a Chemical Dependence Treatment Facility (as defined by the Plan) shall be subject to the maximum number of days as specified in the Schedule of Benefits under the separate Out-Patient Chemical dependence Services/Treatment benefit.

MEDICAL CONDITIONS RESULTING IN INFERTILITY

a. Coverage shall not be excluded for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

b. Benefits are payable for charges for hospital care, surgical or medical procedures or prescription drugs which would correct malformation, disease or dysfunction resulting in infertility, diagnostic tests and procedures, including prescription drugs necessary to determine infertility or that are necessary in connection with hospital care or surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparascopy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Coverage shall not include diagnosis or treatment in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental.

c. Paragraph b is limited to individuals whose ages range from twenty-one (21) through forty-four (44), and whose diagnosis and treatment has been prescribed as part of a physician's overall plan of care.

MEDICAL EXPENSE BENEFITS

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

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

THE DEDUCTIBLE

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

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

COINSURANCE/CO-PAYMENT

After the deductible is satisfied, the Member is responsible for 20% coinsurance of most expenses.
Services of Preferred Providers are subject to the co-payment but not the deductible or coinsurance.

INDEXING

For each calendar year, January through December, the maximum out of pocket amounts shall be subject to indexed increases or decreases.

The index shall be determined by the ratio of the prior year's per capita aggregate expense as compared to the per capita aggregate expense of two years prior.

MEDICAL EXPENSE BENEFITS

1. a. Private Proprietary Hospitals for the treatment of mental and nervous conditions and chemical dependence:

    i. Room and board accommodations. Covered charges for any day on which the patient occupies a private room will not exceed the hospital's most common semi-private room rate; limited to the number of days specified in the Schedule of Benefits.

    ii. Special hospital services required for medical care or treatment rendered by the hospital staff or employees to an in-patient and billed by the hospital.

iii. If an in-patient admission would otherwise be necessary for the treatment of a patient's mental or nervous disorder and the Plan's Managed Benefits Program Administrator, patient and patient's physician agree that a partial hospitalization therapy program would provide the appropriate level of treatment, then such treatment may be authorized. Each visit for such treatment shall reduce the remaining days available under the in-patient psychiatric benefit by one-half (1/2) day.

b. Charges by Other Approved Facilities for the Treatment of Chemical dependence: The term "Approved Facility for the Treatment of Chemical dependence" means a facility or hospital certified by the State of New York or approved by the Joint Commission on Accreditation of Hospitals.

i. Room and board accommodations and services received for the treatment of chemical dependence while confined in an Approved Facility for the Treatment of Chemical dependence as defined above. The maximum duration of coverage while confined in an Approved Facility for the Treatment of Chemical dependence is specified in the Schedule of Benefits.

ii. Out-patient services rendered by the staff of an Approved Facility for the Treatment of Chemical dependence and billed by such facility. Treatment received on an out-patient basis shall be limited as specified in the Schedule of Benefits.

2. Medical or surgical services by a "Physician," including second surgical opinions.

3. The following medical services and supplies that are recommended by a Physician, and are medically necessary:

a. anesthesia, including the charge for its administration;

b. diagnostic laboratory and X-ray services;

c. oxygen and/or rental of equipment required for its administration;

d. X-ray, radium and radioactive isotope therapy;

e. braces, crutches, casts and splints;

f. blood or other fluids actually injected into the circulatory system;

4. If a Covered Person incurs medically necessary expenses which are recommended and approved by a Physician for private-duty nursing services outside of a hospital, the Plan shall pay for such private-duty nursing charges not exceeding the maximum amount specified in the Schedule of Benefits for such charges. Private-duty nursing services shall be payable only if provided by a Registered Nurse (R.N.). If the services of an R.N. are not available, a Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.) or a Registered Nurse Midwife acting within the scope of his license.

5. Initial artificial limbs, eyes (including the first pair of contact lenses following cataract surgery, and prescription lenses for Covered Persons lacking organic lenses) and prosthetic appliances (other than dental prosthetics),; and replacement of such artificial limbs, eyes or prosthetic appliances, if necessitated due to pathological changes or normal growth.

6. The initial purchase only (up to a maximum Plan payment of $500) of a wig to replace natural hair lost as a result of an illness, disease or accident, including loss of hair due to alopecia. (Contact Aetna prior to purchase as limitations may apply).

7. Rental (or purchase at the Plan's option) of Durable Medical Equipment prescribed by a Physician and required for therapeutic use in the treatment of an active illness or injury. Local transportation by a professional ambulance service, or organized voluntary ambulance service, to the nearest hospital or other medical institution for covered medical treatment.

8. Charges for expenses by an ambulatory care center, to the extent such expenses would have been covered if provided by a hospital as part of an inpatient confinement.

9. Dental care or treatment due to accidental injury to sound natural teeth within 12 months of the accident or necessary due to congenital disease or anomaly.

10. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

11. Services by duly licensed podiatrists or licensed Physicians for treatment of diseases, injuries, and malformations of the foot. There are two general exceptions: treatment of weak, strained or flat foot, of any instability or imbalance of the foot, or of any metatarsalgia or bunion is not covered, however, if a cutting operation is used, such treatment will be covered; and treatment of corns, calluses or toenails, including cutting or removal thereof is not covered, however, if such treatment is prescribed by a Doctor of Medicine (M.D.) who is providing treatment for a metabolic disease (such as diabetes meilitus) or a peripheralvascular disease (such as atherosclerosis), it will be covered.

12. Charges related to voluntary sterilization, including Physician and hospital or other facility charges.

13. Maternity care including inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth (96 hours following a cesarean section). If the mother is discharged earlier than the recommended time frames described above, coverage of one home health care visit rendered by a home health agency that is:

    (a) an agency or hospital that has been issued a certificate as a certified home health agency (CHHA) by the New York State Department of Health to provide home health services; or

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

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

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

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

14. Charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. For non-preferred providers, the patient's financial responsibility shall be limited to the amount he would have paid had the provider been a preferred provider.

15. Charges for breast reconstruction after a mastectomy in the manner determined by the attending physician and the patient to be appropriate. This includes (a) all stages of reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications of mastectomy, including lymphedemas.

16. For diabetic patients, the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin diffusion devices and oral agents for controlling blood sugar.

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

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

18. a. Coverage shall not be excluded for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

    b. Benefits are payable for charges for hospital care, surgical or medical procedures or prescription drugs which would correct malformation, disease or dysfunction resulting in infertility, diagnostic tests and procedures, including prescription drugs necessary to determine infertility or that are necessary in connection with hospital care or surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparascopy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Coverage shall not include diagnosis or treatment in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental.
    c. Paragraph b above is limited to individuals whose ages range from twenty-one (21) through

forty-four (44), and whose diagnosis and treatment has been prescribed as part of a physician's overall plan of care.

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

OUTPATIENT SHORT-TERM REHABILITATION

The charges made by:

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

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

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

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

Short-term rehabilitation services consist of:

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

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

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

Not covered are charges for:

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

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

WELLNESS BENEFITS

1 . ROUTINE (in the absence of symptoms) PHYSICAL EXAMINATIONS

For members between the ages of 30 and 49, the health benefits plan will contribute toward the cost of one routine physical examination every two calendar years per person, subject to the following limitations:

$100 maximum per biennial physical examination when performed by an Aetna Choice POS II physician.

$50 maximum per biennial physical examination when NOT performed by an Aetna Choice POS II physician.

These routine services will not be subject to deductibles, co-payments or coinsurance, however, charges in excess of the above limits will be disallowed.

For members, age 50 or over, the health benefits plan will contribute toward the cost of one routine physical examination each calendar year per person, subject to the following limitations:

$100 maximum per annual physical examination when performed by an Aetna Choice POS II physician.

$50 maximum per annual physical examination when NOT performed by an Aetna Choice POS II physician.

These routine services will not be subject to deductibles, co-payments or coinsurance, however, charges in excess of the above limits will be disallowed.

2. ROUTINE (in the absence of symptoms) MAMMOGRAMS

The health benefits plan will contribute toward the cost of routine mammograms as an outpatient or in a physician's office subject to the following conditions and limitations:

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

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

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

The benefits noted above will be subject to deductible and coinsurance or co-payment.

3. WELL CHILD VISITS

The Plan will cover well child visits in accordance with the following schedule, as recommended by the American Academy of Pediatrics (Note, the following schedule may change in accordance with AAP guidelines):

- Up to 7 well child care exams between birth and 12 months
- Up to 2 well child care exams between ages 12 months and 24 months
- Up to 1 visit per calendar year for ages 24 months through 18 years

Services may include a medical history, complete physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

WELL CHILD VISITS AND IMMUNIZATIONS WILL NOT BE SUBJECT TO DEDUCTIBLES, COINSURANCE OR CO-PAYMENTS.

4. IMMUNIZATIONS

The Plan will cover immunizations for children through age 18 as recommended by the Advisory Committee on Immunization Practices (ACIP), except for the Human Papillomavirus Vaccine, which is allowed for covered individuals through age 26. Please refer to the ACIP website for an up to date listing of recommended immunizations: http://www.cdc.gov/nip/recs/child-schedule.htm.

WELL CHILD VISITS AND IMMUNIZATIONS WILL NOT BE SUBJECT TO DEDUCTIBLES, COINSURANCE OR CO-PAYMENTS.

5. ROUTINE (in the absence of symptoms) CERVICAL CYTOLOGY SCREENING

The Plan will cover one cervical cytology screening per calendar year, for women aged eighteen and older as an outpatient or in a physician's office. This includes an annual pelvic examination, collection and preparation of a PAP smear, and laboratory and diagnostic services provided in connection with examining and evaluating the PAP smear. The benefit will be subject to deductibles and coinsurance.

6. ROUTINE (in the absence of symptoms) DIAGNOSTIC SCREENING FOR PROSTATE CANCER

The Health Benefits Plan will contribute towards the cost of routine screenings for prostate cancer as an outpatient or in a physician's office subject to the following conditions and limitations:

*standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer, and

*an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

The benefits noted above will be subject to deductible and coinsurance or co-payment.

7. BONE MINERAL DENSITY MEASUREMENTS, TESTS, DRUGS, OR DEVICES

The Plan will cover bone mineral density measurements or tests if allowed under the criteria set forth by the federal Medicare program or the National Institutes of Health (NIH) for the detection of osteoporosis.

Coverage shall apply for individuals meeting the criteria for coverage under the federal Medicare program or the criteria for coverage under the NIH, and include individuals (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis, (b) with symptoms or conditions indicative of the presence or the significant risk of osteoporosis, (c) on a prescribed drug regimen, (d) with lifestyle factors to such a degree posing a significant risk of osteoporosis, or (e) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

The benefits noted above will be subject to deductible and coinsurance or co-payment.

8. COLONOSCOPIES

The Plan will cover routine colonoscopies, subject to the following limitations:

- One routine colonoscopy every ten (10) years shall be allowed for members age fifty (50) and older;
- Non-routine colonoscopies (when medically necessary and provided for the treatment or diagnosis of an active illness or disease) will not be limited by age;
- Routine colonoscopies shall be subject to copayments and /or deductibles and coinsurance.

MANAGED BENEFITS PROGRAM

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

PRESCRIPTION DRUG EXPENSE BENEFITS

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

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

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

CO-PAYMENT

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

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

COVERED DRUGS

Covered Drugs include only the following:

1. Legend drugs,

2. Insulin on prescription.

3. Tretinoin, all dosage forms (e.g., Retin-A). For individuals over age 25, documentation verifying medical necessity must be submitted to Aetna before reimbursement will be made.

4. Compounded medication of which at least one ingredient is a prescription legend drug.

5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

6. Nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenyl Ketonuria, branched-chain Ketonuria, galactosemia and momocystinuria as administered under the direction of a physician.

7. Syringes and needles for diabetic use.

8. Enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated cause chronic disability, mental retardation or death. Specific diseases for which enteral formulas have proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohns's Disease, gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

9. Prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility, except that coverage shall not include prescription drugs in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental. Coverage is limited to individuals whose ages range from twenty-one (21) through forty-four (44) years.

10. Drugs or devices for bone density as approved by the federal Food and Drug Administration (FDA).

11. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary, and such coverage for such modified solid food products shall not exceed $2,500 per person per calendar year.

12. Drugs or devices for the treatment of erectile disfunction; subject to a maximum of 6 pills per month.

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

EXCLUSIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

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

1. Non-legend drugs;

2. Charges for the administration or injection of any drug.

3. Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use, unless otherwise covered under this Plan or required by law.

4. Prescriptions if benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law;

5. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual unless directed pursuant to an External Appeal;

6. Immunization agents, biological sera, blood or blood plasma;

7. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

8. Any prescription refilled in excess of the number specified by the Physician or allowed by the Plan, or any refill dispensed after one year from the Physician's original order;

9. Drugs that are available without a prescription, unless otherwise specifically included;

10. For Medicare primary eligible members only: Drugs that are covered under Medicare Part B must first be processed by Medicare. Secondary claims may then be submitted to Aetna under the medical portion of the plan.

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

DISPENSING LIMITATIONS

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

NON-PARTICIPATING (PHARMACY) PROVIDERS

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

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

MAIL ORDER PHARMACY

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

PRESCRIPTION DRUG COORDINATION OF BENEFITS

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

    Express Scripts, Inc.
    P.O. Box 390873
    Bloomington, MN 55439-0873
    Attn: Claims Department

CERTIFICATION FOR CERTAIN PRESCRIPTION DRUGS

Certification of the necessity of certain prescription drugs is required before the drug is dispensed by a pharmacy. When one of the prescription drugs shown below is dispensed, expenses incurred will be payable as follows:

- If certification has been requested and the drug is necessary:

  Benefits will be payable at the applicable payment percentage.

- If certification has not been requested and the drug is necessary:

  A penalty equal to 50% of the benefits otherwise payable shall be imposed.

- If the drug is not necessary:

  No benefits will be payable whether or not certification has been requested.

CERTIFICATION PROCEDURES

It is your responsibility to arrange for the prescriber of the drug to call Express Scripts at **1-866- 790-8282** to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Express Scripts will notify you and your heathcare provider of the decision, by telephone and in writing, within three (3) business days of receipt of the necessary information. This notice will show:

- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
- when certification is denied, the procedure to follow if you choose to appeal the decision.

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

LIST OF PRESCRIPTION DRUGS REQUIRING CERTIFICATION

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

- Appetite Suppressants
  (covered only for morbid obesity and attention deficit disorder)
- Growth Hormones
- Retin-A (over age 25)
- Injectable medications

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Contraceptive Drugs or Devices

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

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

LIMITATIONS

GENERAL LIMITATIONS

No benefits shall be payable under the Plan with respect to:

1 Services or expenses incurred prior to the effective date or after the termination date of coverage under the Plan.

2. Any services, supplies, charges or expenses which are not specifically included and listed as covered expenses under a portion of the Plan for which the Covered Person is eligible, including any charge or portion of a charge which is in excess of the usual, reasonable and customary charges as defined by the Plan.

3. Unless otherwise directed pursuant to an External Appeal, those for or in connection with services or supplies that are, as determined by the Plan, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

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

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

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

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

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

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

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

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

4. Unless specifically listed as covered under the Plan, any services not necessary, as determined by the Plan, for diagnosis, care or treatment of an illness or injury; except that circumcisions, abortions, vasectomies and tubal ligations shall be covered as if related to an illness.

5. Unless specifically listed as covered under the Plan, vaccinations, inoculations, preventive shots, and routine physical examinations.

6. Any treatment or service not prescribed or recommended by a Physician or other provider of service defined as eligible for payment by the Plan.

7. Unless specifically listed as covered under the Plan, any charges for hearing aids or their repairs, eye glasses, eye examinations, correction (including surgical) of vision.

8. Any services/treatments for which benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law.

9. Charges for any care or treatment of teeth, gums or alveolar process unless such charges are for:

   a. reduction of fractures of the jaw or facial bones;

   b. surgical correction of cleft lip, cleft palate, or protruding mandible;

   c. removal of stones from salivary ducts;

   d. bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;

   e. freeing of muscle attachments; or

   f. charges for dental care or treatment except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

10. Those for cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

11. Expenses incurred for the treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral-vascular disease.

12. Expenses incurred for Custodial Care Services.

13. Expenses incurred for orthopedic shoes, orthotics and other supportive appliances for the feet.

14. Any illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection or service in the Armed Forces or units auxiliary thereto.

15. Any charges for care or treatment provided or furnished by the United States Government or the government of any country, except to the extent that federal or state law requires the Plan to provide benefits for such care or treatment.

16. Any services for which a charge would not have been made in the absence of coverage, except to the extent that federal law requires the Plan to provide benefits for such services.

17. Any expenses or charges that the member or patient is not legally responsible to pay for.

18. Except as specifically covered under Hospice Care, services or expenses that cannot reasonably be expected to lessen the patients disability and to enable him to live outside of an institution.

19. Charges for services/treatment for which an adequate claim is not filed with the Claims Administrator within 15 months from the date of service.

20. Expenses for prescription drugs or medicines prescribed for use on an out-patient basis, except to the extent specifically listed as covered expenses under the Plan's Prescription Drug Expense Benefits.

21. Any charges for services/treatment related to weight reduction, unless medically necessary or for the treatment of morbid obesity.

22. Any charges. for services/treatment related to an accident, to the extent that benefits for such services/treatment are paid/payable or recovered/recoverable through/from mandatory automobile no-fault insurance coverage.

23. Any charges for services provided by a member of the patient's immediate family.

24. Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.

25. Charges/ expenses for acupuncture therapy except acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered by the Plan.

26. Services to the extent for which an employee, retired employee or dependent:

    A. Is entitled to benefits under either Part A or Part B of Medicare, or,
    B. Would have been entitled to benefits under Part A or Part B of Medicare, except that, although being eligible, failed to enroll for the benefits, or
    C. Would have been entitled to benefits under Part B of Medicare, but having enrolled, failed to continue to make payment of the premiums thereof.
    D. Would have been entitled to benefits under Part A or B of Medicare had the provider not opted out of Medicare.

PRE-EXISTING CONDITIONS

Pre-existing Condition Exclusion - There is an 11-month waiting period (for new employees and their families only) for any condition, injury or disease for which medical treatment or advice was received within a six month period prior to the effective date of coverage.

The exclusionary period shall be reduced by the length of time that the individual was covered under a prior health plan. Any coverage under a prior health plan which was followed by a gap in coverage of more than ninety (90) days shall not be considered.

A prior health plan may include any of the following:

- A group health plan;
- Health insurance coverage;
- Part A or B of Title XVIII of the Social Security Act;
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of title 10, United States Code;
- A medical care program of the Indian Health Service or of a tribal organization;

- A state health benefits risk pool;
- A health plan offered under chapter 89 of title 5, United State Code;
- A public health plan;
- A health benefit plan under section 5(e) of the Peace Corps Act;
- Title XXI of the Social Security Act (State Childrens' Health Insurance Program); or
- Any other arrangement sponsored by a state, the membership composition of which is specified by the state and which is established and maintained primarily to provide health coverage for individuals who are residents of such state and who, by reason of the existence or history of a medical condition-
  - Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or
  - Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

An individual enrolling for the Consortium's Plan for the first time shall be considered a "new" employee by the Claims Administrator, unless waived, in accordance with the above guidelines, by the Office of Risk Management. Failure to obtain a waiver from the Office of Risk Management may cause the new enrollee to be faced with an 11-month pre-existing condition exclusion period.

SUBROGATION / DUTY TO COOPERATE

Subrogation is a legal term that means the substitution of one person in place of another with respect to a claim. Under certain circumstances, if you have a right to sue another person or entity, the health plan may be subrogated, or substituted, to your right to sue.

Therefore**,** in the event that you suffer an injury or illness for which another party may be responsible, we pay benefits as a result of the injury or illness, and there is a statutory right of reimbursement, we will be subrogated, and may succeed to your right of recovery against the party responsible for your illness or injury to the extent of benefits we have paid.

When there is a statutory right of reimbursement, you will be required to obtain the Plan Administrator's consent before entering into any settlement or other agreement with respect to your injury or illness with any third party. This includes any settlement or agreement with respect to your injury or illness, even if it is determined, initially or later, that the third party may not be liable for your injury or illness.

When there is a statutory right of reimbursement, you must not take any action that could prejudice or interfere with the rights of the Plan or the Plan Administrator reserved under this Section.

When there is a statutory right of reimbursement, you must promptly inform the Plan Administrator of the occurrence of any event that may result, or has resulted, in payment under this Plan for which another person or entity may be responsible.

Reimbursement for Expenses We Have Paid. When there is a statutory right of reimbursement, we will be entitled to be reimbursed for the benefits we have paid to you or on your behalf from amounts you received in a settlement with, or judgment against, a party responsible for your illness or injury. This shall be limited to the extent that such amounts are specifically identified for, or allocated to, expenses for which we have paid. You will not be obligated to reimburse us for any legal expenses associated with a legal action instituted on our initiative.

Duty to Cooperate with Us. By participating in this Plan, you agree to cooperate with us fully in any action or proceeding we may undertake against any party responsible for your illness or injury to recover the benefits we have paid to you or on your behalf when there is a statutory right of reimbursement. If you fail or refuse to cooperate with us in the enforcement of our rights under this Plan and applicable laws, you will have violated the provisions of this Plan and will be required to repay us for the amount of benefits we have paid to you. Failure to pay may result in coverage termination. We agree to invoke this requirement only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding $500 under this coverage and there is a statutory right of reimbursement.

Responsibility for Legal Expenses. We agree to pay all expenses associated with any legal action instituted on our initiative. You shall remain solely responsible for all legal fees and other expenses associated with actions you initiate, except that the amount we recover shall be reduced pro rata to the extent of such legal fees and expenses that you incur.

Obtaining Our Consent. When our prior consent is required, we agree not to unreasonably withhold it, and we agree to waive all penalties under these provisions if we fail to respond within 30 days from the date we receive your written request for prior consent.

RECOVERY OF OVERPAYMENT

If a benefit payment is made by the Plan, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

MISCELLANEOUS PROVISIONS

THE COORDINATION OF BENEFITS PROVISION

ORDER OF PAYMENT
When you are covered by more than one health care plan to which the Coordination of Benefits provision applies, the rules below are followed to determine which plan will be the first to pay its benefits:

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

1 . NON-DEPENDENT / DEPENDENT

a. The benefits of a plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of a plan which covers the person as a dependent or COBRA Extendee, except if the person is a Medicare beneficiary;

b. If the covered individual is a Medicare beneficiary, then Medicare is:

i. primary to the plan(s) covering the person as a retiree, or as the dependent of a retiree; and

ii. secondary to the plan(s) covering the person as an active employee or as the dependent of an active employee.

2. DEPENDENT CHILD / PARENTS NOT SEPARATED OR DIVORCED

a. The benefits of the plan of the parent whose birthday falls earlier in a year as determined before those of the plan of the parent whose birthday falls later in that year, but

b. if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

c. If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. DEPENDENT CHILD / SEPARATED OR DIVORCED PARENTS

a. First, the plan of the parent with custody of the child;

b. then, the plan of the spouse of the parent with custody of the child;

c. finally, the plan of the parent not having custody of the child; and

d. if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of

that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. ACTIVE / INACTIVE EMPLOYEE

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

5. LONGER / SHORTER LENGTH OF COVERAGE

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

a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

i. a change in the amount of scope of a plan's benefits;

ii. a change in the entity which pays, provides or administers the plan's benefits; or

iii. a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

b. The claimants length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimants coverage under the present plan has been in force.

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

HOW YOUR BENEFITS ARE PAID

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

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

The following examples illustrates this:

Example 1: Doctor is out of network	
Non-participating doctor's charges = ----------	$550
Reasonable & Customary = ----------	$500
This plan, IF Primary, would pay (@80%) = ----------	$400
Other primary plan pays (@70%) = ----------	$350
This plan will pay ($400-350) = ----------	$50
Member is responsible for = ----------	$150
Example 2: Doctor is in network	
Aetna-participating doctor's charges = ----------	$550
Reasonable & Customary =----------	$500
Aetna's negotiated fee = ----------	$400
This plan, IF Primary, would pay ($400-$20 co-payment) =----------	$380
Other primary plan pays (@70%) =----------	$350
This plan will pay ($380-350) =----------	$30
Member is responsible for = ----------	$20
Example 3: Medicare is primary	
Doctor is in network and accepts Medicare assignment:	
Charges = ----------	$550
Medicare allows = ----------	$400
This plan, IF Primary, would pay ($400# -$20 co-payment) = ----------	$380
Medicare pays (@80% * $400) = ----------	$320
This plan will pay ($400-$320-$20) = ----------	$60
Member is responsible for = ----------	$20
# **Doctors accepting Medicare assignment must reduce their charges to the amount Medicare allows.**	

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

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

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

EFFECTS OF MEDICARE

Medicare coverage is typically provided under 3 parts: A, B and D.

- Part A generally covers hospital care,
- Part B generally covers physician services, and
- Part D covers prescription drugs.
- Medicare Advantage plans, sometimes referred to as Part C, offer HMO-type coverage.

Important Note:

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

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

Federal law requires that Employers offer to active Employees and their covered Dependents, who are age 65 and over, the same health benefits as are available to younger Employees and Dependents. If you are 65 or over, and are covered under your Employees group health plan (this Plan) as an **ACTIVE** Employee, Medicare (if entitled) will then become, generally, the secondary provider of coverage. The Plan will determine what benefits are covered; the remainder of the expenses may then be submitted to Medicare by you for reimbursement.

Medicare Parts A and B

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

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

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

Medicare Part D

This Plan's prescription drug coverage has been determined by an independent actuary to be as good or better (on average for all participants for 2009) as the standard Medicare Part D plan. As such it is deemed to be Creditable Coverage and retirees and their dependents generally do not need to enroll in another Medicare Part D plan. This determination must be made each calendar year. If this Plan's coverage is later determined to be not creditable, members will be informed via newsletter.

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

GENERAL INFORMATION

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

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

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

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

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

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

NAME AND ADDRESS OF THE MEDICAL CLAIMS ADMINISTRATOR

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

NAME AND ADDRESS OF THE PRESCRIPTION DRUG CLAIMS ADMINISTRATOR

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
Attn: Claims Department

DESCRIPTION OF RELEVANT PROVISIONS OF ANY APPLICABLE COLLECTIVE BARGAINING AGREEMENT

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

DATES OF THE PLAN YEAR

July 1st through the following June 30th

INTERNAL REVENUE SERVICE TAX IDENTIFICATION NUMBER

Tax Identification Number 13-3962250

PLAN AMENDMENT/TERMINATION PROCEDURE

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

Appendix A

APPEALS/ GRIEVANCES/ COMPLAINTS

When a claim is denied in full or in part:

Step 1 Initial Actions to Take

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

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

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

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

Aetna, Inc. 575 Pigeon Hill Road WP22 Windsor, CT 06457	Express Scripts Inc. Attn Pharmacy Appeals 6625 West 78th St. Mail Rt. BL0390, Bloomington, Mn 55439.

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

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

Step 2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

Proceed to step 3

Step 3 Claim Determinations

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

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

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** as soon as possible, but no later than 24 hours after receipt of the necessary information.

Post-service Claims
Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

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

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

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

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

Proceed to Step 4 if you are appealing a claim that was denied, or reduced in part, because it has been deemed to be not medically necessary/appropriate, has been deemed to be experimental or investigative.

Proceed to Step 5 if you are appealing a claim denied or reduced for a reason other than medical necessity/appropriateness or being experimental/investigative.

Proceed to Step 6 if you are addressing a concern not included under steps 4 or 5.

Step 4 Appeals of Adverse Benefit Determinations

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

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

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

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

AETNA,
PO Box 981109,
El Paso, TX 79998-1109.
1-877-223-1685

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

A. Level One Appeal

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

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

Standard Appeals
Aetna shall issue a decision within 30 days of receipt of the necessary information to conduct the **appeal**. Aetna will provide written acknowledgement of the filing of the **appea**l within 15 days of its receipt.

The notice of the appeal determination will include:

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

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

B. Your Right to an External Appeal

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

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

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

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

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

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

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

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

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

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

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or, in the case of a rare disease, based on the physician's certification and such other evidence as the insured, the insured's designee or the insured's attending physician may present, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure;or
A clinical trial for which you are eligible (only certain clinical trials can be considered). For the purposes of this section, your attending **physician** must be a licensed, board certified or board eligible **physician** qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If, through the first level of Aetna's internal **appeal** process, you have received a final **adverse benefit determination** upholding a denial of coverage on the basis that the service is not medically **necessary** or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal **appeal**, you have 45 days from the receipt of such waiver to file a written request for an external **appeal**. Aetna will provide an external appeal application with the final **adverse benefit determination** issued through the first level of Aetna's internal **appeal** process or its written waiver of an internal **appea**l.

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

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

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

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

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

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

Your Responsibilities

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

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which you receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal **appea**l. Aetna has no authority to grant an extension of this deadline.

C. ***Level Two Appeal***

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

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

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)
Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an Expedited Appeal)
Aetna shall issue a decision within 15 days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 days of receipt of the request for a level two **appeal**.

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

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

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

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Step 5 Grievances

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

Aetna will acknowledge receipt of the **grievance** within 15 days after its receipt by Aetna.

Grievance Determinations

Expedited Grievances

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

Standard Grievances

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

Grievance Appeals

Expedited Grievances

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

Standard Grievances

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

If you still not satisfied with, you may proceed to Step 7 to submit your grievance to the Consortium's Joint Governance Board

Step 6 Complaints

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

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

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

If your complaint is still not resolved, you may proceed to Step 7 to submit your complaint to the Consortium's Joint Governance Board.

Step 7 Joint Governance Board

If, after complying with steps 5 or 6, your complaint or grievance has not been resolved, you may submit it to the Joint Governance Board for review. **Please note that the Joint Governance Board will NOT address Adverse Benefit Determinations, which are subject to Step 4.**

Submit all documentation that you wish to be reviewed by the Joint Governance Board, **within 60 days after receipt of the notice of determination from Step 5 or 6.** The Board will review your complaint or grievance at a regularly scheduled meeting and render a decision. The decision will be communicated to you, in writing within 15 days.

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

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

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

b. The Board will determine if your request for a hearing will be granted. If granted, the Board will set a hearing date.

   1. Your complaint or grievance should be presented to the Board at the hearing by you and/or your personal representative.

2. The Board will review all materials submitted through the hearing process and will provide you with a written response as to its determination within 15 days. That determination is final.

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

:

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

Additional information may be obtained from the Insurance Department's website:
http://www.ins.state.ny.us/complhow.htm

Appendix B

PRIVACY POLICY

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

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

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

Uses and disclosures

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

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

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

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

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

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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

Appendix C

DOMESTIC PARTNER POLICY

Introduction

Same-sex domestic partners who meet the requirements of this policy shall be eligible to enroll for coverage under the health benefits plan. Opposite-sex domestic partners shall not be eligible for coverage. In the event that same-sex marriage becomes legal in the member's state of residence, this policy may be rescinded. Domestic partners who enrolled prior to same-sex marriage becoming legal in their states of residence will be given a one-year grace period.

Basic Eligibility Requirements

- Each partner must be at least eighteen (18) years of age and competent to enter into a contract;
- The partners must not be related by blood in a manner that would bar marriage in the state of New York;
- The partners must share a common primary residence and have done so for at least two (2) years (730 days) immediately prior to the date of signing the attached affidavit;
- The partners must be in a close, committed and financially interdependent relationship;
- Neither partner may be, or have been, a member in another domestic partnership within the last two (2) years (730 days);
- The partners must file a Domestic Partner Affidavit with the member employer's benefits office, including proof of joint residency and proof of financial interdependence.

How to Enroll a Domestic Partner

To enroll a same-sex domestic partner, a member must contact his/her employer's benefits office. Enrollment must occur during the employer's annual open enrollment period, or within 30 days of loss of coverage under another health benefits plan due to termination of employment, reduction of hours, termination of employer contributions, exhaustion of COBRA continuation coverage, exceeding a lifetime limit on all benefits, being a member of a class of employees who are no longer eligible for benefits or change of residence to a location in which no benefits are available.

District Eligibility Requirements

Districts that participate in the Consortium have discretion over certain aspects of eligibility and cost sharing. You must contact the member employer's benefits office for additional information.

Children of Domestic Partners

Children of eligible domestic partners may be enrolled for coverage if they meet all other criteria of the health plan, such as age and student status, and are dependents of the domestic partner in accordance with the Internal Revenue Code.

Tax Considerations

There may be federal and state tax implications for employees who enroll domestic partners in their employer's health benefits plan. Unless the domestic partner is also a "dependent" in accordance with section 152 of the Internal Revenue Code (IRC), without regard to gross income, and you file a Dependent Tax Affidavit with the member's employer's benefits office, the fair market value of the coverage provided must be reported as imputed income to the employee.

The amount of the imputed income will generally be the cost difference between the premium for single coverage and the premium for family coverage.

Premium Reimbursement Accounts / Flexible Spending Accounts

Your employer may allow members to pay certain health insurance premiums and/ or unreimbursed medical expenses on a pre-tax basis though Premium Reimbursement Accounts or Flexible Spending Accounts. However, unless a domestic partner meets the definition of dependent, in accordance with the Internal Revenue Code, neither premiums paid for domestic partner coverage nor unreimbursed medical expenses of the domestic partner may be paid through these accounts.

Loss of Coverage

In the event the member loses coverage due to termination of employment or reduction of hours, the covered domestic partner, and covered children if applicable, shall be eligible for continuation coverage similar to that offered to married spouses and children under the Consolidated Omnibus Reconciliation Act (COBRA). Strict time limits apply to notification, enrollment and coverage. Please refer to the Plan Document for additional information.

Termination of Domestic Partner Relationship

In the event the domestic partnership terminates or the partner no longer meets the criteria for eligibility, the employer's benefits office must be notified, in writing, within fourteen (14) days. If the domestic partner (and children if applicable) was covered by the Plan on the day before the relationship ended, then continuation coverage, similar to that offered to married spouses who divorce pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), may be offered.

A member who terminates a domestic partner relationship will not be allowed to enroll a new domestic partner for a period of two (2) years from the date the employer is notified of the termination.

Domestic partners who lose coverage under the Plan for any reason shall receive a certificate of creditable coverage from the member employer's benefits office.

Death of Member

An enrolled domestic partner may continue coverage, similar to a surviving spouse, in the event of the member's death. If the surviving partner marries or enters into another domestic partnership, s/he will no longer be eligible for coverage.