The Saratoga Hospital EPO $250 Summary Plan Description 2020

Plan Administered by

SARATOGA HOSPITAL

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Claims Administered by

CDPHP®

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3100

20-14711

MEDICAL PLAN SPD TEMPLATE

The model document that follows is a Summary Plan Description (SPD) template provided by CDPHN as a courtesy to employers offering a group health plan administered by Capital District Physicians' Healthcare Network, Inc. ("CDPHN"). The document is intended to comply with the requirements under the Employee Retirement Income Security Act ("ERISA") to provide plan participants with a Summary Plan Description (SPD) describing the material terms of the plan in a manner calculated to be understood by the average plan participant.

The template was designed so that it generally will need to be customized by the employer to describe the specific plan design features of the employer's plan. The template was designed to describe the standard administrative procedures used by CDPHN and variable language describing the most common benefit plan features adopted by our clients, but may not reflect every term of your own plan(s). In the event that your plan does not adopt all of the standard administrative procedures used by CDPHN, for example, this template may need to be further modified to reflect your actual practice.

While this template was developed in conjunction with our own attorneys, we do not and cannot provide legal advice or represent or warrant that it is compliant for your particular program(s). You should have your own employee benefits lawyers review the content of this document before adapting for your own use.

Please note that if the employer is a covered entity under Section 1557 of the Affordable Care Act because it receives federal funding from the Department of Health and Human Services (HHS), the employer may also need to include a copy of its Section 1557 nondiscrimination notice as part of this document. Please consult your own legal counsel regarding those requirements.

Once completed, you will be responsible for distributing this document to plan participants in accordance with the requirements of the applicable ERISA regulations. A final copy of the document you distribute (or a substitute document of your choosing, if you do not use this template) should be provided to CDPHN, to include on your employer website portal.

Creditable Prescription Drug Coverage: If you or your covered dependents are eligible for Medicare or will become eligible for Medicare within the next 12 months, a federal law gives you more choices about your prescription drug coverage. It's important for you to know that your Saratoga Hospital medical plan prescription drug coverage provides creditable coverage—coverage that, overall, is at least as good as the Medicare Part D standard plan. If you opt out of medical coverage, you will not have creditable coverage with Saratoga Hospital. More information is available in the *Notice of Creditable Coverage* section.

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Saratoga Hospital EPO $250

What You Need to Know About This Booklet

This booklet is intended to provide a Summary Plan Description ("SPD") of the key terms of the Saratoga Hospital EPO $250. The Plan is also commonly referred to as the EPO $250. In this booklet, it is referred to simply as "the Plan."

This SPD is not a contract of employment, but a reference source about the Employer's benefits. This SPD in no way limits the right of the Employer to change or discontinue this Plan or any benefit Plan at any time. Although it is the intention of Saratoga Hospital (the "Employer") to maintain the Plan indefinitely, the Employer reserves the right to terminate, suspend, discontinue, modify, or amend the Plan at any time with notice to all Participants.

While every effort has been made to clearly and accurately describe the Plans in this book, there are additional details that are only covered in the official Plan documents and other Plan policies maintained by CDPHN, the Plan's third party administrator. While every effort has been made to provide a clear and accurate description of the key terms of the Plan, in the event of a discrepancy between this SPD and the official Plan document, the Plan document governs.

All services, plans and benefits are subject to and governed by the terms of the Plan and of applicable tax regulations and Internal Revenue Service (IRS) guidance. The information herein is believed accurate as of the date of publication and is subject to change without advance notice.

Please read these materials carefully and refer to them when you need information about how the Plan works.

CDPHN Member Services Center

This SPD is your guide to the benefits available through the Plan. Please read it carefully and refer to it when you need information about how the Plan works and to find out how to handle service issues. It is also an excellent source for learning about any special programs available to you as a Plan participant.

If you cannot find the answer to your question in the booklet, contact the Plan's Member Service Center by logging on to www.cdphp.com. You can also call the Member Services Center toll-free number on your ID Card or contact the Plan Administrator at the address shown in the *Plan Information* section.

IMPORTANT

Please take time to read this booklet carefully so that you may get the most from the Plan. Some of the key points for you to know include the following:

- Only Medically Necessary health services are covered under the Plan, with the exception of certain preventive care services, (e.g., routine physicals, routine eye or hearing exams).
- The fact that a Physician or Provider has performed or prescribed a procedure or treatment, or that a procedure or treatment may be the only available treatment for a condition, does not mean the procedure or treatment is covered under the Plan. If you have any questions or need additional information about what is covered under the Plan, contact CDPHN Member Services at the telephone number on your ID Card.
- Service(s) rendered in conjunction with a non-covered service are also not covered. For example, anesthesia given in connection with a cosmetic procedure would not be covered.
- The names of Plan service providers and the nature of the services provided may be changed from time to time, at the Claim Administrator's discretion, and without prior notice or approval.
- It is important for you to follow the procedures described in this booklet and to give the Administrative Agent, CDPHN, all the information required under the Plan. Failure to follow procedures or provide requested information may result in financial penalties or denial of benefits.

TIPS FOR NEW PLAN PARTICIPANTS

- Keep this booklet where you can easily refer to it.
- When you receive a Summary of Material Modifications (SMM) notifying you of changes to the Plan, keep it with this booklet.
- Keep your ID Card(s) in your wallet.
- See the *Emergency Care* section for Emergency care guidelines.

INTRODUCTION—Plan Overview and Highlights

The Plan is a group health plan sponsored and maintained on a self-funded basis by the Employer. This means that Plan claims are paid by The Saratoga Hospital and that benefit are not insured by a carrier. The benefits described in this booklet will be provided only to eligible employees of the Employer and their eligible dependents who are properly enrolled in the Plan.

Plan claims are administered by Capital District Physicians' Healthcare Network, Inc. (CDPHN). As claims administrator, CDPHN handles and processes all claims and performs claim-related functions. However, CDPHN has no underwriting liability for any of the benefits described in this booklet.

The Plan Administrator retains exclusive authority and discretion to interpret the terms of the Plan described in this booklet. See the *Plan Information* section for more information about the Plan Administrator.

Effective Date

This booklet describes the benefits in effect as of 1/1/2020.

Words That Are Used Frequently in This Booklet.

Within this document, the The Saratoga Hospital EPO $250 is referred to as "The Plan." Saratoga Hospital will be referred to as "Employer." Capital District Physicians Healthcare Network, Inc. will be referred to as "CDPHN." The word "you," "your," "yours," or "Participant" refers to you, the employee of the Employer who is enrolled under the Plan, and to members of your family who are enrolled under the Plan.

See the *Definitions* section for a glossary of other defined terms used in this booklet..

Plan Overview

The Plan is an Exclusive Provider Option (EPO) plan that has been designed to provide you with high quality medical benefits that also are affordable. The primary features of the EPO are described below. To enroll in the EPO plan, you must live or work within the CDPHN service area. Even if you live outside the CDPHN local service area, the Plan also offers the National Network for services rendered outside of the area covered by CDPHN's local Standard Network. See *If You Live Outside the Area* for more information.

The Plan requires Participants to use a provider in the CDPHN EPO network as described below. CDPHN Network Provider information is available at www.cdphp.com.

In order for you to receive ***benefits***, your services MUST meet the requirements below:

- Services must be provided by a Network Provider; or
- In the case of an Emergency, you receive care as described in the Emergency Care section.

Less paperwork is another benefit of using the Network approach. When you receive services from a Network Provider, typically the Provider will submit claims to CDPHN and reimbursement will be paid directly to the Provider, without the need for you to file a claim.

Note: Under certain circumstances the Plan *may* authorize care from non-Network Providers. For example, in the case of organ transplants, services may not be available from Network Providers. In such a situation, care provided by a designated non-Network Provider will be covered if the services are Covered Services and prior authorization is received from the CDPHN Medical Director, or his/her designee.

The Primary Care Physician, Coordination of Care, and Referral Requirements

When you enroll in the Plan, you do **not** need to select a Primary Care Physician ("PCP"). Also, the Plan does **not** require that you get a Referral to visit an In-Network specialist. Although the Plan does not require you to identify a PCP, you may still wish to coordinate your health care needs through one physician who can provide medical care, maintain complete and accurate medical records and assist you in making well-informed health care decisions.

Selecting A Primary Care Physician.

Although not required by the Plan, you should consider selection of a Primary Care Physician (PCP), if you have not already identified one for yourself and your family members. Care coordinated by your PCP ensures that one doctor has a complete picture of your health needs and medical history, and can assist you in making well-informed health care decisions.

When you enroll in the Plan, you should select a PCP from the CDPHN Network for yourself and one for each enrolled member of your family from the Provider directory. If you choose a new physician, an initial appointment should be made with that physician soon after your coverage is effective so that he/she may become familiar with your medical needs and start your medical record. Call your PCP first for all your health care needs.

For information on how to select a PCP, and for a list of the participating providers, visit www.cdphp.com or call Member Services at the phone number on your ID Card. If, for any reason, you are not satisfied with your PCP, you are free to change to another PCP from the CDPHN Network as often as needed. You should, however, attempt to establish an ongoing relationship with your PCP.

Cost Sharing and Plan Benefits

Annual Deductible.

The Plan imposes an annual Deductible before the Plan provides benefits for certain services. The Deductible year is the calendar year. The deducible applies only to non-Domestic Network charges. Please note that certain services are not subject to the deductible. See the Plan's Summary of Benefits and Coverage or the *Schedule of Benefits* for a list of those services. See *Deductibles and Maximums* for more information on the Plan's Deductible.

Copayments and Coinsurance.

After the Deductible has been met (if applicable), the Plan will begin paying benefits for Covered Services. Each time you access care, you will be responsible for making a Copayment (fixed flat dollar amount) or paying Coinsurance (a percentage of the claim cost) that applies to the specific situation. You are responsible for paying Copayments or Coinsurance, as indicated, up to the Out-of-Pocket Maximum. Please note that certain services are not subject to Deductible, Copayments or Coinsurance. See the Plan's Summary of Benefits and Coverage or *Schedule of Benefits* for a list of those services.

Annual Out-of-Pocket Maximum.

No matter how large your medical health care costs may be in a given year for services covered under the Plan, your annual out-of-pocket expenses for medical and prescription expenses that are Covered Services will not exceed the Plan's Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, the Plan will provide benefits for Covered Services at 100% for the remainder of the year. (See *Deductibles and Maximums* for detail on individual and family Out-of-Pocket Maximum and how they affect you and your enrolled dependents.)

If You Live Outside the Area.

The Plan Administrator will let you know if you live beyond the CDPHN Standard Network local service area. If you do, you will still be eligible for Plan Benefit coverage through the National Network. Through the National Network, you will have the option to choose Participating Practitioners and Providers in your local geographic area. Or, if you live on the border of the CDPHN Standard Network service area, you may choose to use either the CDPHN Standard Network or the National Network, or both interchangeably. The In-Network level of benefits applies whether you use the CDPHN Standard Network or the National Network.

Comprehensive Coverage.

When you receive specialty care, you pay an office visit Copayment for each specialist visit. If you need specialty care that cannot be provided by a Network specialist, you may attempt to obtain prior written approval of the CDPHN Medical Director, or his/her designee, who will identify a non-Network specialist who can provide the Medically Necessary services. You will receive benefits at the In-Network level for these prior-approved Covered Services if it is deemed in CDPHN's sole discretion that such services are not available in CDPHN's local or national MagnaCare or First Health networks.

Credentialed Provider Network.

CDPHN has established a network of health care Providers who will provide health care services to persons covered under the Plan. Locally, the Plan utilizes the CDPHN Standard Network of Providers that have agreed to provide services at negotiated rates. [insert if Employer bought up to National Network: The Plan also offers a National Network of Participating Providers for those who live outside the CDPHN Standard Network local service area. These Networks consist of highly qualified Physicians and other medical professionals and facilities that work with you and your Physician to keep you healthy, and provide quality care and treatment when you are ill or injured. The quality health care services provided must meet accepted high standards set by the national medical organizations and CDPHN. CDPHN uses a team of nurses who work with the CDPHN Medical Director, or his/her designee, and Network Providers to insure these quality health care guidelines are followed.

All Participating Practitioners are carefully screened and subjected to periodic review by CDPHN. The education, experience, credentials, administrative procedures, and standard practices of all health care Participating Practitioners and Providers are assessed carefully before they are admitted to the CDPHN Network. If you are now seeing a doctor who is not in the CDPHN Network, you should encourage your physician to contact CDPHN's Provider Services Department to consider joining the CDPHN Network.

Medically Necessary Care.

The Plan will provide benefits for service or care that is Medically Necessary. Medically Necessary care consists of those services defined by CDPHN's Medical Director, or his/her designee, that:

- Are necessary to treat and/or alleviate symptoms of an Illness, Injury, disorder, or condition.
- Are rendered at an appropriate level of intensity and in an appropriate facility or setting.
- Can reasonably be expected to promote effective outcomes.
- Are provided efficiently and facilitate quality of care.

More specifically, this includes treatments needed to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in Illness, Injury, or infirmity, interfere with such person's ability for normal activity, or threaten a major handicap.

Examples of unnecessary care are:

- When you receive care in a hospital for care that can be provided in a physician's office or outpatient surgical center, or are admitted for care that can be provided without admission to a hospital as a bed patient;
- When you are in a hospital for longer than is necessary to treat your condition; or
- When hospitalized, you receive ancillary services not required to diagnose or treat your condition.

In certain cases, your Physician will make the *initial* decision as to whether care is Medically Necessary. In other cases, the CDPHN Resource Coordination Department will make the *initial* decision. The CDPHN Medical Director or his/her designee will make the *final* decision as to whether care is Medically Necessary, and benefit Coverage is based on this decision.

In cases involving Network Providers, the CDPHN Medical Director, or his/her designee, may decide whether care is Medically Necessary at the time the care is proposed but **before it is given to you.** In cases involving non-Network Providers, the CDPHN Medical Director, or his/her designee, may decide *either before or after the care is given to you* that the care was not Medically Necessary. In those situations, you will be personally responsible for the cost of any care that the CDPHN Medical Director, or his/her designee, determines is, or was not, Medically Necessary. It is therefore important that you ensure that a Medical Necessity determination is made by the CDPHN Medical Director before you receive treatment out-of-Network.

See *Prior Authorization and Precertification Penalties* for more information on services that always require an advance Medical Necessity determination.

Prior Authorization and Precertification Penalties.

You or your physician must notify CDPHN's Resource Coordination Department for prior approval when he or she recommends hospitalization or services for, but not limited to, an inpatient hospital stay, inpatient surgery, skilled-nursing facility care, home health care, inpatient medical rehabilitation unit or facility services, accidental dental services, or hospice care. Prior approval is also required for the purchase or rental of certain durable medical equipment, certain prescription drugs, orthotics or prosthetic devices over $1000, and for organ transplants, private duty nursing, and home dialysis. For EPO plans, the Covered Services requiring Prior Authorization are listed in the *CDPHP Prior Authorization Guideline* in the column labeled "UBI EPO/HDEPO."

Generally, Participating Practitioners arrange prior authorization from CDPHN; however, **it is your responsibility to make sure that Prior Authorization is received, if required, before receiving a service In-Network or Out-of-Network.** If prior authorization is not obtained, when required, benefit coverage may be reduced or denied.

After review, CDPHN will notify the Participant, the Participant's Physician, and the hospital or facility whether the care is determined to be a Covered Service and Medically Necessary. If it is determined that it is not a Covered Service or Medically Necessary for the Participant to receive the proposed services, CDPHN will contact the Participant and the Physician with the determination.

Note: Prior Authorization is NOT required in an Emergency Care situation.

Participants may be charged a precertification penalty in cases where Prior Authorization is required but not obtained.

Emphasis on Prevention.

Because the Plan covers the cost of such services as annual physicals, well-child visits, and certain preventive screenings (e.g. mammograms, colonoscopies, etc.) in full, with no copay, deductible or coinsurance, it is easier to stay healthy without spending a lot of money. When you see your PCP or are referred by your PCP to another network physician for services other than preventive, you pay an office visit Copayment.

SECTION ONE—Definitions

The following are definitions of terms used in this Summary Plan Description (SPD). For your convenience words that are defined in this section appear throughout the document text with initial capitalization. These terms, regardless of capitalization, shall have the meanings indicated, unless the context clearly requires otherwise. The following are general definitions, and the presence of any definition in this Section is not, in and of itself, an indication of the existence of a benefit under the Plan.

- "ACA" means the Affordable Care Act, which is comprised of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and any subsequent amendments, and regulatory guidance thereunder.
- "Accidental Dental" means trauma to sound natural teeth caused by something other than a natural function including chewing and grinding of the teeth.
- "Administrative Agent" means the individual(s) or corporation appointed by the Plan Administrator to administer claims and carry out administrative tasks in connection with the Plan. The Plan Administrator is empowered to appoint and remove the Administrative Agent from time to time as it deems fit. In the event no Administrative Agent has been appointed, or an Administrative Agent resigns from a prior appointment, the Plan Administrator shall administer the HRA Plan. At the time of the Effective Date, the Administrative Agent is Capital District Physician's Health Network, Inc.
- "Adoptive Child" means a child or infant on whose behalf a Participant is actively engaged in adoption proceedings, but such proceedings have not yet been completed.
- "Affiliated Employer" means the Employer and any corporation which is a member of a controlled group of corporations which includes the Employer; any trade or business which is under common control with the Employer; any organization which is a member of an affiliated service group which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury Rules and Regulations.
- "Allowed Charge" means the amount the Plan will use as the basis for calculating Plan Benefits. In-Network, the Allowed Charge is the amount payable to Participating Providers as defined in Provider contracts. Out-of-Network, the Allowed Charge is determined by CDPHN and is the Usual, Customary, and Reasonable charge.
- "Appeal" means a formal request for reconsideration of a denial of benefits or adverse Claim determination in accordance with the Plan's Claims and appeals procedures.
- "Benefits" means amounts paid by the Plan for Covered Services in accordance with the *Schedule of Benefits*.
- "Brand Name" means a trade name medication. Compounded drugs are considered Brand and must contain at least one legend drug which has a valid NDC number.
- "Calendar Year" means January 1st through December 31st of the same year.
- "Case Management" means a collaborative process of assessment, planning, facilitation, and advocacy for options and services, to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
- "CDPHN Medical Director" means is a Physician employed by CDPHN who has overall responsibility for the planning, supervision, and delivery of, and the determination of Medical Necessity for, medical care covered under the Plan.
- "CDPHN Resource Coordination" means the department within CDPHN responsible for authorizing services and coordinating medical resources to address patient care.
- "Claim" means a formal request for benefits under the Plan in accordance with the Plan's Claims and appeals procedures.
- "Claim Form" means a document used to request payment of benefits under the Plan.
- "Claimant" means any Participant, or an authorized representative acting on behalf of a Participant, asserting a Claim for eligibility or Benefits.
- "Claims Reviewer" means the individual or entity assigned to review Claims or Appeals for a benefit. Where a Benefit's materials specify that Claims be sent to the Administrative Agent or another third party administrator, then the Administrative Agent or third party administrator shall be the Claims Reviewer.
- "Clinical Trial" means a controlled scientific study designed to assess the effectiveness of procedures, drugs and devices. Typically, Clinical Trials are performed after a treatment shows promise during limited testing. Clinical Trials are usually organized into four phases:
  - Phase I: generally the first time a new drug, device or treatment is used in humans. Phase I trials usually involve a small number of participants (20-80) and are short-term (3-12 months). The objective of a Phase I trial is to evaluate the safety of a new drug or treatment, determine a safe dosage range, and identify side effects.
  - Phase II: the study treatment or drug is usually given to a larger population (100-300) who have the disease being studied. The objectives of a Phase II Clinical Trial are to assess the safety and effectiveness of the treatment or drug and to

refine the dose, use of the device or the technique of the procedure. A Phase II trial can be randomized and may be a blinded, placebo or standard therapy controlled trials. A Phase II trial may take anywhere from several months to several years to complete.
    - Phase III: the study treatment or drug is usually given to large groups of people (1,000 to 3,000) to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and collect information that will allow the drug or treatment to be used safely. Due to the larger population in the study, less common side effects may be identified. A Phase III trial typically includes control groups, is randomized, and may include blinding of the participants and/or researchers. These trials may involve multiple institutions and take months, years, or up to ten years or longer to complete.
    - Phase IV: usually conducted after the FDA has given approval for a drug or device to be marketed. A Phase IV trial may be required by the FDA as condition of approval. The objectives of this phase are to assess how well a treatment works in wide range of participants and gather more data about potential adverse reactions. "COBRA" means the Consolidated Omnibus Reconciliation Act of 1985, as amended from time to time, and regulatory guidance thereunder.
- "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time, and regulatory guidance thereunder.
- "Coinsurance" means the percentage of the Allowed Charge Participants must pay for certain Covered Services, typically after a Deductible has first been met. See the *Schedule of Benefits* for information on Coinsurance under the Plan.
- "Copayment" means a fixed amount Participants must pay for certain Covered Services. See the *Schedule of Benefits* for information on Copayments (if any) under the Plan.
- "Coverage" means enrollment in the Plan that entitles a Participant to Benefits for Covered Services.
- "Covered Services" means the Health Services for which the Plan pays Benefits. See the *Schedule of Benefits* for a list of Covered Services. The Plan does not pay Benefits for Excluded Services, expenses in excess of the Allowed Charge, non-Network Providers, or services that are not Medically Necessary.
- "Deductible" means the amount Participants must pay for certain Covered Services before the Plan pays benefits. Certain Covered Services are not subject to a Deductible. See the *Schedule of Benefits* and *Deductibles and Maximums* for information on Deductibles under the Plan.
- "Dependent" means a Subscriber's spouse, child or other person other than the Subscriber meeting all relevant applicable eligibility requirements set forth under the Plan and enrolled as a plan Participant.
- "Diagnose" or "Diagnosis" means an act or process of identifying or determining the nature of Illness, disease or Injury through examination.
- "Domestic Network" means a specialty network of preferred In-Network Providers for which the Plan pays a higher level of Benefits. Not all Plans offer a Domestic Network. See *Plan Network* and the *Schedule of Benefits* for information regarding whether the Plan offers a Domestic Network.
- "Domestic Partner" generally means a person with whom the Subscriber has shared a primary residence for at least 6 months, is financially dependent or interdependent, and is in a romantic relationship that is intended to be permanent. The partners must be at least 18 years old, unmarried, not related by blood or marriage in a way that would bar their marriage to each other, and each must be the sole Domestic Partner of the other.
- "Durable Medical Equipment" or "DME" means items that are primarily used to serve a medical purpose; can withstand repeated use; are generally not useful to a person in the absence of Illness, Injury or disease; and are appropriate for use in the home.
- "Effective Date" means the effective date of the terms of this SPD as set forth in the *Introduction* Section.
- "Emergency Care" means Health Services required because of 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:
    - Placing the health of the person afflicted with such condition or others in serious jeopardy;
    - Serious impairment to such person's bodily functions;
    - Serious dysfunction of any bodily organ or part of such person, or
    - Serious disfigurement of such person.
- "Eligible Employee" means an Employee who satisfies the Plan's eligibility criteria described in the *Eligibility* Section.
- "Employee" means a person who is a common law employee regularly scheduled to work for the Employer in an employee/employer relationship. Employee does not include an independent contractor or consultant of the Employer.
- "Employer" means the Employer listed on the front cover of this document, any Participating Employer, any successor which shall maintain the Plan, and any predecessor which has maintained the Plan.
- "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time, and regulatory guidance thereunder.

- "Excluded Services" or "Exclusions" means services and expenses that the Plan does not cover. Exclusions include expenses that are not Medically Necessary (except for certain covered Preventive Services), that exceed the Allowed Charge, or that are otherwise not Covered Services. See the *Exclusions* section for a list of Excluded Services.
- "Experimental and/or Investigational" means services and/or devices (medical, behavioral health, surgical, or other treatments, procedures, techniques, drug, and pharmacological therapies) not proven to be safe and efficacious. A service and/or device is considered experimental or investigational when either of the following conditions exist:
  - Pharmaceutical agents, medical devices, biological agents, food items, and radiation-emitting products do not have final approval from the U.S. Food and Drug Administration (FDA), or approval by any other United States governmental agency.
  - The evidence in peer review medical literature is not conclusive and the service or supply has a beneficial effect on health outcomes or is as beneficial as any established alternatives.

  Examples of these services and devices include, but are not limited to:
  - procedures, drugs and devices which have demonstrated promise in the laboratory, but whose efficacy has not been established through Clinical Trials;
  - procedures, drugs, and devices which have demonstrated promise in the laboratory and limited testing in humans, but whose efficacy has not been conclusively established because Clinical Trials are either incomplete or have yet to begin;
  - FDA approved drugs used for Diseases or conditions other than the ones that the FDA has approved indications for use (commonly known as "off-label drugs"); and
  - Drugs that are not commercially available.
- "Family Deductible" means the Deductible that applies for those enrolled in levels of Coverage higher than Single Coverage (e.g., Employee +1, Family, etc.). For some plan designs, the entire Family Deductible must be satisfied before the Plan will begin paying Benefits for any Participant in the family. For other plan designs, the Individual Deductible will apply separately to each family member, and the Plan will begin paying Benefits when the first Participant in the family has incurred expenses for Covered Services equal to the Individual Deductible (this is known as an "embedded" Individual Deductible). See *Deductibles and Maximums* for more information regarding how the Family Deductible works under the Plan.
- "Family Out-of-Pocket Maximum" means the Out-of-Pocket Maximum that applies for those enrolled in levels of Coverage higher than Single Coverage (e.g., Employee +1, Family, etc.). For some plan designs, the entire Family Out-of-Pocket Maximum must be satisfied and there is no embedded Individual Out-of-Pocket Maximum. For other plan designs, the Individual Out-of-Pocket Maximum will apply separately to each family member, and the Out-of-Pocket Maximum will be satisfied with respect to a Participant when the first Participant in the family has incurred eligible out-of-pocket expenses equal to the Individual Out-of-Pocket Maximum (this is known as an "embedded" Individual Out-of-Pocket Maximum). See *Deductibles and Maximums* for more information regarding how the Family Out-of-Pocket Maximum works under the Plan.
- "FMLA" means the Family and Medical Leave Act, as amended from time to time, and regulatory guidance thereunder.
- "Formulary" means a list of covered Prescription Drugs compiled by the Pharmacy Benefit Manager or Plan Administrator.
- "Generic" means a Prescription Drug that has the equivalency of the Brand Name and is classified as "generic" on the Plan's Formulary. This Plan will consider as a Generic drug any FDA approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist.
- "Health Services" means Medically Necessary services to treat Illness, diseases, or Injuries, or certain Preventive Care, and generally aligns with those services that qualify as Medical Care as defined by Code Section 213(d). Health Services do not include services that are not actually provided to Plan Participants.
- "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulatory guidance thereunder.
- "Home Health Care" means a program of care provided by an agency engaged in providing home health care services including, but not limited to, skilled nursing services and having a valid existing agreement with CDPHN to provide said services to Plan Participants.
- "Hospice Care" means the care and treatment of a Participant who has been certified by his/her Physician as having a life expectancy of six months or less, and which is provided by a hospice organization certified under the New York Public Health Law or under a similar certificate process required by the state in which the hospice is located.
- "Hospital" means an acute general care facility operated pursuant to law which: (a) is primarily engaged in providing diagnostic therapeutic services for surgical or medical Diagnosis, treatment, and care of injured and sick persons by, or under the supervision of, a staff of Physicians; (b) has 24-hour nursing services by registered professional nurses; and (c) is not (other than incidentally) a place for rest, custodial care or the aged; or a nursing home, convalescent home or similar institution.
- "ID Card" means the card that CDPHN issues to Plan Participants showing that they are entitled to receive Benefits under the Plan.
- "Illness" means a condition where the body fails to function normally due to physical or mental disorders or substance abuse.

- "Individual Deductible" means the Deductible that applies for those enrolled in Single Coverage. For some plan designs, the Individual Deductible may also apply separately to each family member for those Participants with levels of Coverage higher than Single Coverage (e.g., Employee +1, Family, etc.), so that the Plan begins paying Benefits for a Participant as each Participant in the family has incurred expenses equal to the Individual Deductible (this is known as an "embedded" Individual Deductible). For other plan designs, the entire Family Deductible must be satisfied before the Plan will begin paying benefits for any Participant in the family for those with levels of Coverage higher than Single Coverage. See *Deductibles and Maximums* for more information regarding how the Individual Deductible works under the Plan.
- "Individual Out-of-Pocket Maximum" means the Out-of-Pocket Maximum that applies for those enrolled in Single Coverage. For some plan designs, the Individual Out-of-Pocket Maximum may also apply separately to each family member for those Participants with levels of Coverage higher than Single Coverage (e.g., Employee +1, Family, etc.), so that the Out-of-Pocket Maximum is met for a Participant as each Participant in the family has incurred eligible out-of-pocket expenses equal to the Individual Out-of-Pocket Maximum (this is known as an "embedded" Individual Out-of-Pocket Maximum). For other plan designs, the entire Family Out-of-Pocket Maximum must be satisfied and there is no embedded Individual Out-of-Pocket Maximum. See *Deductibles and Maximums* for more information regarding how the Individual Out-of-Pocket Maximum works under the Plan.
- "Injury" means accidental physical harm to the body caused by unexpected external means.
- "In-Network" means Covered Services rendered by Participating Practitioners or other Participating Providers, eligible for reimbursement at In-Network levels as indicated in the *Schedule of Benefits*.
- "Legal Guardian" means a person who is appointed by an order of a court of competent jurisdiction to be the guardian of another person.
- "Limiting Age" means the age at which a Dependent child is no longer eligible for Plan benefits unless Totally Disabled. In general, the limiting age is 26, but may be modified with respect to certain categories of Dependent children not required by law to be covered by the Plan, if so stated in the Eligibility section.
- "Medically Necessary" means those Health Services determined by CDPHN's Medical Director or his/her designee to be necessary to treat and/or alleviate symptoms of an Illness, Injury, disorder or condition; rendered at an appropriate level of intensity and in an appropriate facility or setting; reasonably be expected to promote effective outcomes; provided efficiently, and which facilitate quality of care. More specifically, this includes treatments needed to prevent, Diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in Illness, Injury, or infirmity; interfere with such person's ability for normal activity, or threaten a major handicap.
- "Medicare" means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.
- "Mental Health Condition" means a treatable manifestation of a condition in an individual that:
  - is a behavioral or psychological syndrome or pattern;
  - the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning);
  - is not merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals);
  - reflects an underlying psychobiological dysfunction;
  - is not solely a result of social deviance or conflicts with society;
  - has diagnostic validity using one or more sets of diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment); and
  - has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- "National Network" means a network of Providers that has contracted with the National Network Provider to provide services at negotiated rates outside the local service area of the CDPHN Standard Network. Not all Plans offer a National Network. See *Plan Network* for information regarding whether the Plan offers a National Network.
- "National Network Provider" means the entity with which the Plan has contracted to provide the National Network.
- "NDC Number" means a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. The Food and Drug Administration (FDA) publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC Directory which is updated daily.
- "Network" means the Domestic Network, Standard Network, and/or National Network.
- "Network Physician" means a "Participating Practitioner."
- "Network Provider" means a "Participating Provider."
- "Neuromusculoskeletal Disorder" means a condition with associated signs and symptoms related to the nervous, muscular, or skeletal systems, typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

- "No-Fault Insurance" means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.
- "Open Enrollment Period" means a period during which Eligible Employees have an opportunity to enroll, disenroll, add or drop Dependents, or select an alternate health plan being offered to them by the Employer, or a period when uninsured Eligible Employees and their Dependents, if any, may obtain Coverage without presenting evidence of a qualifying election change event.
- "Out-of-Network" means services rendered by non-Participating Practitioners or other non-Participating Providers. Out-of-Network services are not covered by the Plan, except where the CDPHN Medical Director approves coverage at In-Network levels on the basis that the Covered Services are not available In-Network.
- "Out of Pocket Maximum" means expenses for Deductibles, Coinsurance and Copayments that must be met by a Participant or a family (Subscriber and Dependents) before the Plan will pay 100% of the In-Network Allowed Amount for Covered Services, for that Participant or family for the remainder of the Plan Year. See the *Schedule of Benefits* and *Deductibles and Maximums* for information on Out-of-Pocket Maximums under the Plan.
- "Participant" means a Subscriber and his/her enrolled Dependents.
- "Participating Employer" means an Affiliated Employer that has adopted the Plan.
- "Participating Practitioner" means a Physician or medical professional, such as an acupuncturist, physical therapist, or clinical psychologist, who has agreed under contract with CDPHN locally and/or the National Network Provider nationally to provide Health Services to Participants at negotiated rates.
- "Participating Provider" means a Provider that has agreed under contract with CDPHN locally and/or the National Network Provider nationally to provide Health Services to Participants at negotiated rates.
- "Physician" means a doctor of medicine or osteopathy licensed to practice medicine, or other duly licensed practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the schope of his or her license, such as a chiropractor or podiatrist. A physician's assistant, or a nurse practitioner may be seen by a Participant in place of a physician, but only when they are supervised by a physician.
- "Pharmacy Network" means a group of participating pharmacies that have contracted to furnish comprehensive services at a reasonable cost to Participants and the Plan.
- "Plan Administrator" means the "named fiduciary" and "plan administrator" as these terms are used in ERISA. The Plan Administrator is the Employer, committee other person(s) appointed by the Employer to serve as Plan Administrator, which is listed in the Plan Information section.
- "Plan Number" means the 3-digit number assigned to the Plan, which is listed in the Plan Information section.
- "Plan Sponsor" means the Employer.
- "Plan Year" means the 12-month period that is the coverage period for the benefits provided for under the Plan, which is listed in the Plan Information section.
- "Precertification" means "Prior Authorization."
- "Prescription Drugs" means any of the following:
  - Legend drugs (an FDA-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription") that can only be legally dispensed when they are ordered by a Physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law in New York (or equivalent in other states);
  - Medically Necessary enteral formulas which have 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, if prescribed by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law ini New York (or equivalent in other states);
  - Injectable insulin; and/or
  - Insulin needles or syringes, but only when dispensed upon a written prescription of a licensed Physician/Provider.
- "Preventive Care" or "Preventive Services" means routine healthcare that includes check-ups, patient counseling and screenings to prevent Illness, disease and other health-related problems. Certain Preventive Services are required under the ACA to be provided to Participants free of charge with no Deductible, Coinsurance or Copayment if provided In-Network. See *Preventive Care* for more information on Preventive Services covered by the Plan.
- "Primary Care Physician" or "PCP" means a Physician who has an agreement with CDPHN, to provide primary care to persons covered under the Plan. PCPs are typically general practitioners, or practitioners of internal medicine or family medicine. PCPs for children are typically pediatricians. A physician's assistant or a nurse practitioner may not be selected as a Primary Care Physician.
- "Prior Authorization" means a process whereby CDPHN's Resource Coordination Department must make a determination of Medical Necessity before the Participant receives certain Prescription Drugs or Covered Services in order to receive

the maximum allowable Benefits. If Prior Authorization is not obtained where required, Benefits may be denied or penalties may apply. See *Prior Authorization and Precertification Penalties* and *Prescription Drugs* for more information.

- "Prosthetic Device" means a Medically Necessary replacement of a missing body part by an artificial substitute.
- "Protected Health Information" or "PHI" has the same definition as set forth in the Privacy Standards of HIPAA, and generally means individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. Employer access to PHI is limited to those individuals designated by the Employer in separate documents maintained by the Plan.
- "Provider" means a licensed medical professional or facility that provides Health Services. This includes Physicians, Hospitals, Skilled Nursing Facilities, Home Health Care agencies, ambulance services, laboratories or other licensed health care facilities or practitioners, such as an acupuncturist, physical therapist, or clinical psychologist.
- "Self-Referral Services" means services that do not require a PCP referral to be covered In-Network, and include the following:
  - Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
  - Emergency Care services;
  - Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
  - Maternal depression screening;
  - Urgent Care;
  - Outpatient mental health care;
  - Diabetic eye exams from an ophthalmologist;
  - Vision Care
- "Standard Network" means the CDPHN local network of health care Providers who have contracted to provide health care services to Participants at negotiated rates that do not exceed the Allowed Charge.
- "Qualified Beneficiary" has the same definition as set forth in COBRA, and generally means an individual covered by a group health plan on the day before a qualifying event who is either an Employee, Employee's spouse, or the Employee's dependent child, who has rights to elect continuation coverage under COBRA.
- "Qualifying Election Change Event" means an event that entitles an Eligible Employee to make a new election for Plan Benefits, which may include enrolling, disenrolling, changing Plan options, or changing enrolled Dependents. Qualifying Election Change Events are determined by the Employer and described in the Employer's Code Section 125 Cafeteria Plan document (also referred to as a flexible benefits plan). Qualifying Election Change Events typically include:
  - Change in marital status (e.g., marriage, divorce, legal separation, or annulment).
  - Death of a Participant.
  - Birth or adoption of a child.
  - Change in the number of eligible Dependents because of any other event (e.g., divorce, gaining or losing custody of a child, a child exceeding the maximum age of eligibility, etc.).
  - Change in the Employee's employment status with the Employer (e.g., hire, termination, change from full-time to part-time status, non-union to union status, leave of absence, geographic location, job classification, etc.) that affects the Employee's or Dependents' eligibility for the Plan.
  - Change in the employment status of a Dependent (e.g., hire, termination, change from full-time to part-time status, non-union to union status, leave of absence, geographic location, job classification, etc.) that affects the Dependent's eligibility for health insurance through another employer.
  - A Dependent's employer's open enrolment period that is different than the Plan's Open Enrollment Period.
  - HIPAA special enrollment rights.
- "Referral" or "Referral System" means the system within managed care that ensures a Participant's medical care is coordinated. In a Referral System, if a Participant needs services from a specialist, the Participant must work with his/her Primary Care Physician to select a network specialist, and the PCP must provide a Referral for care. Whenever a Participant receives services from a Network Provider without a required PCP Referral, coverage will be denied. See *The Primary Care Physician, Coordination of Care, and Referral Requirements* for information regarding whether the Plan uses the Referral System.
- "Rehabilitation Facility" means is a hospital or other facility licensed to provide Rehabilitative Care.
- "Rehabilitative Care" means care involved in the process of restoring a person's functional abilities after a disabling Injury or Illness. It does not include the maintenance of an achieved level of function.
- "Short-Term, Acute-Care General Hospital" means a licensed institution primarily engaged in providing: inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis; treatment or care of injured or sick persons by or under the supervision of Physicians; and 24-hour nursing service by or under the supervision of registered nurses. None of the following are considered Short-Term, Acute-Care General Hospitals:
  - A division or unit of a Short-Term, Acute-Care General Hospital where the average length of stay is more than 30 days;
  - Places primarily for nursing care;

- Skilled nursing facilities;
- Convalescent homes, health-related facilities or similar institutions;
- Institutions primarily for custodial care, rest, or as domiciles;
- Health resorts, spas, sanitariums, or tuberculosis hospitals;
- Outpatient surgical centers;
- Infirmaries at schools, colleges, or camps; or
- Places for the treatment of alcoholism, or drug abuse, mental care, or rehabilitation.

- "Single Coverage" means the level of Plan Coverage that provides benefits to the Subscriber only and no Dependents. Also called "Individual Coverage" or "Employee-only Coverage."
- "Skilled Nursing Facility" means a facility providing therapeutic services to inpatient Participants requiring medical and skilled nursing care as defined under Section 2801 of the Public Health Law in New York (or equivalent in other states) and which is qualified to participate as an extended care facility under Title XVIII of the Social Security Act.
- "Specialty Pharmacy" means a Pharmacy that provides specialty medications such as self-injectables, drugs that require special distribution, handling, are at limited supply, and/or certain oncology medications.
- "Step Therapy" means the requirement to try an equally effective drug before a more expensive Brand Name drug; Step Therapy may also ensure that two medications are used together if they are more effective.
- "Subscriber" means any person, other than a Dependent, who meets all relevant applicable eligibility requirements under the Plan, and who applies and is accepted for Coverage by the Plan. Subscribers include enrolled Eligible Employees, enrolled retirees (if eligible under the Plan), and enrolled Qualified Beneficiaries.
- "Surgical Procedures" means those medical procedures consisting of: (a) operating procedures for the Diagnosis and treatment of an Illness or Injury; (b) endoscopies; (c) correction of dislocations; (d) treatment of fractures; and (e) any puncture or incision of tissue or skin requiring the use of surgical instruments, including any pre- and post-operative care usually rendered in connection with such operation or procedure.
- "Third Party" means another person or a business entity who is not the Plan, the Administrative Agent or the Plan Participant.
- "Total Disability" or "Totally Disabled" means, in the case of a Dependent child, that the child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law) or physical handicap.
- "Urgent Care" means medical care for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Care. Urgent Care may be rendered in a Physician's office or Urgent Care Facility.
- "Urgent Care Facility" means a licensed facility which provides medical assistance to treat minor and non-life-threatening Injuries, Illnesses, disorders or conditions.
- "Usual, Customary, and Reasonable" or "UCR" means, with regard to charges for services or supplies, the lowest of the:
  - usual charge by the Physician/Provider for the same or similar services or supplies;
  - usual charge of most Physicians/Providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies, as determined with reference to the 80th percentile of the FAIR Health database;
  - actual charge for the services or supplies; or
  - negotiated rate a Physician/Provider has agreed to accept.

  The Administrative Agent has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.
- "Waiting Period" means the time between the first day of employment as an Eligible Employee and the first day of coverage under the Plan as described in *Employee Eligibility*.

SECTION TWO—How the Plan Works

This booklet is the Summary Plan Description (SPD) for the Saratoga Hospital EPO $250. (referred to throughout this SPD simply as "the Plan.") It is provided to Participants as an explanation of the key terms of Plan Benefits. Additional details can be found in the official Plan documents, which remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the Plan described herein.

As Administrative Agent for the Plan, Capital District Physicians' Healthcare Network, Inc. (CDPHN), a subsidiary of Capital District Physicians' Health Plan, Inc. (CDPHP), handles and processes all claims and performs claim-related functions. However, CDPHN has no underwriting liability for any of the benefits provided by the Plan and described in this booklet. The benefits described herein will be provided to eligible employees of the Employer enrolled in the Plan ("Subscribers"), and to eligible members of their families who have enrolled in the Plan ("Dependents").

Categories of Expenses.

Typically, services provided under a medical benefit plan fall into two categories: facility services and professional services. Often, a service rendered will consist of both of these types of services. As an example, an inpatient hospital stay has a facility bill (for the room, board and services related to the stay: operating rooms, X-ray equipment, supplies, etc.) and a professional bill (for services of the Physicians or other medical practitioners: e.g., the surgeon, anesthesiologist, and technician who reads the X-rays). The Plan provides benefits for both facility and professional services.

Plan Network.

In order for you to receive Benefits, services must be rendered by a Practitioner or Provider affiliated with the Plan's Network of Providers (a "Participating Practitioner" or "Participating Provider") as described below:

- **In-Network Benefits (Domestic).** The Plan has defined a preferred Domestic Network, which renders the highest level of Benefits and typically the lowest out-of-pocket expense for Participants. The Domestic Network is comprised of Saratoga Hospital owned facilities & physicians who have generally agreed to provide the most favorable rates to the Plan.
- **In-Network Benefits (Standard).** CDPHN has established a local network of health care Providers who provide health care services to Participants at negotiated rates that do not exceed the Allowed Charge.
- **In-Network Benefits (National).** For Participants who reside outside the CDPHN local service area for the Standard Network, the Plan has contracted with Providers through the National Network Provider (MagnaCare and First Health). These Participants will have an ID Card with the National Network Provider logo on the front of the card. Services rendered by the National Network are covered as In-Network services for these Participants.
- **Out-of-Network Benefits.** As a general rule, the Plan does not provide any benefits for health care services provided by non-Network Providers, except in the case of Emergency Care. If you choose to receive care outside of the Network, you will be solely responsible for any billed charges.

Note: Under certain circumstances the Plan may authorize care from non-Network Providers. For example, in the case of organ transplants, services may not be available from Network Providers. In such a situation, care provided by a designated non-Network Provider will be covered at the In-Network level of benefits **if prior authorization is received from the CDPHN Medical Director, or his/her designee.**

To maximize value, the Plan is designed to encourage Participants to use a Network of Providers as described below:

- **In-Network Benefits (Domestic).** The Plan has defined a preferred Domestic Network, which renders the highest level of Benefits and typically the lowest out-of-pocket expense for Participants. The Domestic Network is comprised of Saratoga Hospital owned facilities & physicians, who have generally agreed to provide the most favorable rates to the Plan.
- **In-Network Benefits (Standard).** CDPHN has established a local network of health care Providers who provide health care services to Participants at negotiated rates that do not exceed the Allowed Charge. When you receive Covered Services from a Participating Provider, the Plan provides a higher level of Benefits thanif you received those services from a non-Network Provider.
- **In-Network Benefits (National).** For Participants who reside outside the CDPHN local service area for the Standard Network, the Plan has contracted with Providers through the National Network Provider (MagnaCare and First Health). These Participants will have an ID Card with the National Network Provider logo on the front of the card. Services rendered by the National Network are covered as In-Network services for these Participants.
- **Out-of-Network Benefits.** The Plan provides Out-of-Network Benefits so you can see any Provider you choose, even if he or she is not a Participating Practitioner or Provider. If you receive care that is otherwise a Covered Service but is rendered by a non-Participating Practitioner/Provider, Out-of- Network benefits will apply. Note that you will be responsible for a greater portion of the cost for Out-of-Network Benefits, and in certain cases there may be no Out-of-Network coverage at all for a particular service.

Refer to the *Schedule of Benefits* to determine the coverage available In-Network and Out-of-Network, and/or call CDPHN Member Services for clarification at the phone number shown on your ID Card.

Note: Under certain circumstances the Plan may authorize care from non-Network Providers to be provided at In-Network levels. For example, in the case of organ transplants, services may not be available from Network Providers. In such a situation, care provided by a designated non-Network Provider will be covered at the In-Network level of Benefits **if prior authorization is received from the CDPHN Medical Director, or his/her designee.**

Reimbursement of Expenses.

In-Network Services.

Network Providers are responsible for submitting a claim for eligible expenses for each service to CDPHN. In the event that a Participant is billed by a Participating Provider for Covered Services, the Participant should contact CDPHN by phone or in writing at the phone number or address shown on your ID Card.

The patient name and CDPHN ID number, date of service, provider name and address, description of service, and proof of payment (receipt and EOB) must be provided with the claim.

Maximizing Your Benefits.

The Plan has been designed to provide you with high quality medical benefits that also are affordable. If you use the Domestic Network, you will have the lowest cost-sharing and receive the highest level of Benefits. When you use the managed-care system of Network Providers and Referrals, you will be responsible for a Copayment or Deductible and Coinsurance for office visits and other In-Network services. If you receive services from a non-Network Provider, the Plan won't pay any benefits (except in the case of Emergency Care).

Less paperwork is another benefit of using the managed-care approach. When you receive services from a Network Provider, typically the Provider will submit claims to CDPHN and reimbursement will be paid directly to the Provider, and you will not need to submit any Claim Forms.

The Plan has been designed to provide you with high quality medical benefits that also are affordable. If you use the Domestic Network, you will have the lowest cost-sharing and receive the highest level of Benefits. When you use the system of Network Providers, you will be responsible for a the applicable: Copayment, Deductible or Coinsurance at the level for In-Network services described in the *Schedule of Benefits*.

If you receive services from a non-Participating Provider, you will be responsible for payment of those services.

Less paperwork is another benefit of using Participating Providers. When you receive services from Participating Providers, they will complete and submit Claim Forms directly to CDPHN and reimbursement will be paid directly to the Provider, and you will not need to submit any Claim Forms. If you use non-Participating Providers, in many instances, you will need to pay for the services up front and you will be responsible for mailing CDPHN a Claim Form and receipts in order to get reimbursement.

SECTION THREE—Eligibility and Enrollment

Saratoga Hospital Look-Back Measurement and Stability Periods Policy

General

Saratoga Hospital has elected twelve consecutive months as its Measurement Period to determine if an employee is eligible to participate in the Saratoga Hospital health plan, and twelve consecutive calendar months as the Stability Period for employees who averaged 30 hours of service per week or 130 hours of service per month (hereinafter simply referred to as "30 hours of service per week") during the applicable Measurement Period. The Measurement and Stability Periods will apply to all regular common law employees to determine full-time status. However, Saratoga Hospital may exclude from eligibility for coverage any individuals classified as a consultant, agency temp, or independent contractor, even if a court or governmental agency later determines that the individual was a common law employee.

In some cases employees may be eligible for coverage even if they do not qualify under these Measurement Period rules, if they satisfy the more generous eligibility criteria currently outlined in the plan documents for the Saratoga Hospital benefits program.

Should the employee qualify for benefits under these Measurement Period rules, medical benefits will be made available to the employee and his/her eligible dependents under the same terms and conditions as benefits are provided to employees who qualify for benefits under the health plan's regular eligibility criteria.

Standard Measurement and Stability Periods

- *Standard Measurement Period*. The Standard Measurement Period starts on October 31st for calendar plans] and ends November 1st for calendar plans of the following year. This Measurement Period may be adjusted annually based on the payroll dates, in accordance with applicable regulations. Saratoga Hospital is permitted to treat as a measurement period a period that ends on the last day of the payroll period preceding the payroll period that includes November 1 (the date that would otherwise be the last day of the measurement period), provided that the Measurement Period begins on the first day of the payroll period that includes October 31 (the date that would otherwise be the first day of the measurement period). Saratoga Hospital may also treat as a measurement period a period that begins on the first day of the payroll period that follows the payroll period that includes October 31, provided that the measurement period ends on the last day of

the payroll period that includes November 1of the prior calendar year. Saratoga Hospital may make this determination annually in order to ensure that its Administrative Period does not exceed 90 days.

- *Standard Administrative Period*. The Standard Administrative Period will start in November each year, on the day after the last day of the Standard Measurement Period as adjusted for payroll periods (as described above). The Standard Administrative Period shall not exceed 90 days, and shall end each year on December 31st.
- *Standard Stability Period*. The Standard Stability Period is the calendar year, which is also the health insurance plan year.

Crediting Service During a Measurement Period

Credited hours of service are defined by applicable regulations, and will include all hours for which the employee is paid, or entitled for payment for:

1. the performance of duties for Saratoga Hospital or any member of its controlled group/affiliated service group, if applicable; and
2. each hour for which an employee is paid, or entitled to payment by Saratoga Hospital or a controlled group member on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability and workers' compensation for which a pay supplement is made), layoff, jury duty, military duty, leave of absence, or on-call time. For disability and workers' compensation, this includes credit for hours paid by Saratoga Hospital or a third party for supplemental benefits (e.g., a group disability insurance carrier), if any, but excludes hours that were paid exclusively for statutory workers' compensation or statutory disability benefits.

Credit will also be given for on-call time when the employee is required to remain on-call on the employer's premises, or for which the employee's activities while remaining on-call are subject to substantial restrictions that prevent the employee from using the time effectively for the employee's own purposes.

The total hours of service during the applicable Measurement Period will be divided by 52 weeks or 12months, except as explained for the averaging rule for FMLA, jury duty or USERRA leave, below.

When computing average hours during a Measurement Period, Saratoga Hospital will either (1) exclude any periods of unpaid Family and Medical Leave (FMLA), jury duty, or military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), or (2) credit the employee with hours of service for such leave periods at a rate equal to the employee's average weekly hours of service during the weeks in the Measurement Period that are not part of the unpaid leave period. To the extent Saratoga Hospital cannot determine the number of hours for which an employee is paid on account of a period of incapacity, Saratoga Hospital will utilize this method to calculate the number of hours.

If the result is that the employee's average hours of service during the Measurement Period were at least 30 per week or 130 per month, then medical benefits will be made available to the employee for the duration of the Stability Period that follows, so long as the employee remains an employee on the books and records of the Company.

Initial Measurement and Stability Periods

If, at the time of hire, it cannot be determined whether an employee is reasonably expected to average at least 30 hours of service per week (e.g., in the case of seasonal, variable-hour, or part-time employees who are regularly scheduled to work less than 30 hours per week), the employee will be subject to an Initial Measurement Period to determine medical coverage eligibility. If, at the time of hire, an employee is reasonably expected to average at least 30 hours of service per week, then the employee will become eligible for coverage the first of the month after the date of hire.

Saratoga Hospital has elected twelve consecutive calendar months as the Initial Measurement Period to determine if a part-time, seasonal or variable-hour employee is eligible to participate in the health plan, and twelve consecutive calendar months as the Initial Stability Period for such employees who averaged 30 hours of service per week during the Initial Measurement Period. If the employee did not average 30 hours of service per week during the Initial Measurement Period, then the employee will be ineligible for coverage during the Initial Stability Period, but only until the point that the employee has completed a Standard Measurement Period and Standard Administrative Period. From that point on, the employee's eligibility shall be determined under the Standard Measurement Period and Standard Stability Period rules.

The Initial Measurement Period will begin on the first day of the month following the employee's date of hire. When computing the employee's hours worked during the Initial Measurement Period, Saratoga Hospital may treat as the Initial Measurement Period the period that begins on the first day of the first payroll period that begins after the date that would otherwise be the first day of the Measurement Period (and the Initial Measurement Period will end on the last day of the payroll period that includes the date that would otherwise be the last day of the Initial Measurement Period).

The Initial Stability Period will begin on the first day of the second calendar month following the employee's service anniversary.

Rehire Following Separation from Service or Leave

If an employee is rehired or reinstated following a separation from service or leave with Saratoga Hospital, then the employee may be subject to a new Initial Measurement Period in accordance with this policy if the employee was separated for a period of 13 weeks or more If the employee has not been separated for 13 weeks or more, then the employee shall resume the same Initial Measurement Period or Standard Measurement Period that the employee was in prior to the separation, and if the employee was in an Initial Stability Period or Standard Stability Period, shall resume coverage immediately upon rehire without serving a new Waiting Period, with coverage effective no later than the first day of the calendar month following rehire.

However, in the event that the employee's separation from service was at least four consecutive weeks during which the employee was not credited with any hours of service, and the length of that break exceeds the number of weeks of that employee's immediately preceding period of employment with Saratoga Hospital (or its controlled group members), then the employee may be treated as a new hire and subject to a new Initial Measurement Period. For purposes of the preceding sentence, the duration of the immediately preceding period of employment is determined after crediting the employee with service for FMLA, jury duty and USERRA leave.

Change in Employment Status

Special rules apply if, during the Initial Measurement Period, an employee changes from regular full-time status to part-time, seasonal or variable-hour status where the employee is reasonably expected to work fewer than 30 hours of service per week in the new employment status, or vice versa.

- Regular Full-Time Status to Part-time, Seasonal or Variable-Hour Status. If an employee changes from regular full-time status to part-time, seasonal or variable-hour status during an Initial or Standard Stability Period, then Saratoga Hospital will assess whether the employee is expected to work 30 hours per week as a part-time, seasonal or variable-hour employee and will assess the hours worked to determine whether the employee actually averaged 30 hours of service per week during the most recent Measurement Period. If the employee is expected to average 30 hours of service per week, or if the employee actually did average 30 hours of service per week during the most recent Measurement Period, then the employee remains on coverage for the remainder of the Stability Period. If the employee is not expected to average 30 hours of service per week, and the employee did not average 30 hours of service per week during the most recent Measurement Period, then the employee will lose eligibility for coverage effective the first day of the calendar month after the change in status.
- Part-time, Seasonal or Variable-Hour Status to Regular Full-Time Status. If an employee changes from part-time, seasonal or variable-hour status to regular full-time status during an Initial or Standard Stability Period, the part-time, seasonal or variable-hour employee would not be required to be offered benefits under the Affordable Care Act rules unless the part-time, seasonal or variable-hour employee had averaged 30 hours of service per week during the most recent Measurement Period. However, Saratoga Hospital's more generous eligibility policy provides that the employee would be entitled to benefits effective the first day of the month following the change in employment status regardless of how many hours the employee worked during the most recent Measurement Period.

Dependent Eligibility.

You also have the option to elect coverage for certain family members, if they qualify as eligible Dependents as described below. Please note that you may be required to submit acceptable proof of Dependent Child eligibility, such as proof of marriage, adoption or legal guardianship.

Coverage for Your Spouse.

The term "spouse" as used in this SPD means your current same- or opposite-sex spouse recognized under state and federal law. Legally separated Spouses remain eligible for coverage until your marriage ends in divorce or annulment. Ex-Spouses are not eligible for coverage under any Employer health plan once a divorce is final, even if a divorce decree mandates that an employee provide coverage for the ex-spouse.

If you enroll a Domestic Partner.

You may enroll a Domestic Partner with whom you are in a committed romantic relationship, if you:

- have lived together for at least 6 months,
- are both mutually responsible for basic living expenses such as food, shelter, medical expenses, and other financial obligations, and
- intend to remain so permanently.

A Domestic Partner may be the same or opposite sex, must not be related to you by blood and must be at least the age of consent in the state in which he or she resides. Neither you nor your partner may have had a different Domestic Partner or spouse in the last 6 months. You must provide a signed affidavit and acceptable documentation to enroll your Domestic Partner for coverage. You may also enroll your Domestic Partner's child, as described in the section describing *Eligible Children* below.

However, if your Domestic Partner (or his or her child) does not meet the IRS definition of a tax dependent, then you will need to pay taxes on the value of the Plan benefits provided to them. Please note that the IRS definition of a tax dependent for health insurance purposes is broader than those dependents that are claimed on your tax return. For example, children are considered your dependent to age 26, and the income limits do not apply. Where your Domestic Partner is not your tax dependent, your Employer will tax you on the value of the Plan coverage by "imputing income" on your Form W-2. This means that extra taxes will be withheld from your pay to reflect the value of benefits subsidized by the Employer. The imputed income amount will usually be based on the COBRA cost for the Plan coverage.

You should consult with a tax advisor to determine if your Domestic Partner or his/her child(ren) qualify as your tax dependent for health insurance purposes. You may be required to provide your Employer with a signed affidavit attesting to the Dependent's tax qualified status in order to avoid imputed income with respect to such individual's participation in the Plan. In general, the requirements for a Domestic Partner or your partner's child to be your tax dependent for purposes of dental insurance are:

- the individual lives with you for the entire calendar year (and the relationship must not violate local law);
- during the calendar year, you must provide more than half of the total support (as described below) for the individual;
- the individual cannot be claimed as a qualifying child on anyone else's federal tax return; and
- the individual must be a U.S. citizen, a U.S. national, or a resident of the U.S.

To determine whether you provide more than half of the total support for your Domestic Partner or his/her child, you must compare the amount of support you provide with the amount of support your Domestic Partner (or your partner's child) receives from all sources, including Social Security, welfare payments, the support you provide, alimony and child support, and the support domestic partner, or the child of such an individual provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for your Domestic Partner (or child), you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information). Please note that an individual could qualify as a tax dependent for health insurance purposes, but not on your tax return, if that individual earns more than the exemption amount as defined in Code Section151(d) ($4,150 for 2020, indexed for inflation annually), but still receives more than half of his or her support from you.

If you submit a signed affidavit certifying that your Domestic Partner or partner's child is your tax dependent, and it is later determined that the value of those benefits should have been taxable to you, then you will be required to reimburse your employer for any liability it may incur for failure to withhold Federal, state, or local income taxes, Social Security taxes, or other taxes related to such benefits.

Coverage for Your Child(ren)

A child is eligible only if all of the following are met:

- The child is under the Limiting Age (eligibility continues through the last day of the calendar month in which the child turns 26); **and is:**
  - your biological child;
  - your adopted or proposed Adoptive Child;
  - your step child from your current marriage; or
  - a child for whom you are the legal guardian; or
  - your foster child.
- You may also enroll a child of your Domestic Partner who is under age 26. However, these children must live with you and your Domestic Partner in a parent-child relationship and you or your Domestic Partner must be responsible for the welfare and material needs of the child.Additionally, the child(ren) must be reported as your or your Domestic Partner's dependent(s) on your or your Domestic Partner's most recent federal tax return, or you or your Domestic Partner must be required to provide coverage for the child(ren) by court order. If the tax dependent status changes for the child(ren), you must notify the Employer.

Qualified Medical Child Support Orders (QMCSOs)

In addition to the above, your child may be eligible for health care coverage from the Plan under the terms of a Qualified Medical Child Support Order (QMCSO), even if you do not have legal custody of the child or if certain enrollment restrictions might otherwise apply for the child (for example, it is outside open enrollment).

Federal law requires that a QMCSO meet certain form and content requirements to be valid. A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all the following:

- The order specifies your name and last known address, and the child's name and last known address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

- The order states the period to which it applies; and
- The order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

You must notify the Plan Administrator and elect coverage for that child within 31 days of the court order being issued. If the Plan receives a valid QMCSO and you do not enroll the child, the custodial parent or a state agency may enroll the child (and may also enroll you for coverage, if you are not already enrolled for benefits). If you have any questions or you would like a copy of the written procedures for determining whether a QMCSO is valid, please contact the Employer.

Extending a Child's Eligibility Due to Disability

Eligibility may be continued under the Plan for a covered Dependent child who reaches the Limiting Age, is Totally Disabled, and who became so prior to the Limiting Age. The child must also be:

- unmarried; and
- dependent upon the Eligible Employee as the primary source of financial support.

To be eligible for this continued coverage, you must submit an application within the 90 days before the child's 26th birthday (or within 30 days after hire, if you are hired by the Employer after the child's 26th birthday) providing evidence of the child's Total Disability. You can obtain the forms by calling the Employer, who will facilitate the process with the Administrative Agent.

If the Total Disability status is approved, the Plan Administrator and/or Administrative Agent may require, at reasonable intervals following the Dependent child's reaching the Limiting Age, subsequent proof of the child's Total Disability and dependency . Failure to provide requested information may result in loss of coverage for your Dependent.

If Your Child Is Adopted

Coverage for your legally adopted or Adoptive Child is effective on the date the child is adopted or placed with you for adoption. You must request coverage for the child by calling the Employer within 30 days of the placement or adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

Coverage for Newborns

Coverage for your newborn child is effective on the child's date of birth. You must request coverage for the child by calling the Employer within 30 days of the child's birth.

If Your Child Does Not Live With You

All Employer health plan options provide some coverage nationwide, even if your child does not live within the Plan option's service area.

There are several ways your child can be covered at in-network rates. First, if your child does not live with you, but lives in the Plan's service area, s/he can choose a Participating Practitioner in the service area and receive care at in-network rates.

A child covered by the Plan who does not live in the health plan's service area can choose a Participating Practitioner in the network and travel to the network service area for In-Network care.

If your child lives in an area where there is no access to Network Providers, the Plan will pay benefits for Urgent Care at In-Network rates if there are no Network Providers within a reasonable distance of the child's home ZIP code, subject to limits for the Allowed Charge. If an Emergency occurs outside of your service area, out-of-area Dependents should obtain necessary care as described under *Emergency Care*, then contact their Physician to coordinate follow-up care.

Ineligible Dependents.

The following persons are specifically excluded from being considered a Dependent and may not be covered under this Plan, even if they are your tax dependent, or are otherwise dependent upon you for support:

- an ex-spouse from whom you are divorced;
- an unborn child;
- anyone residing outside the United States;
- insert if applicable: a foster child;
- your parents, siblings, grandparents, grandchildren, in-laws, or other relatives or individuals living in your home, even if you claim them as dependents on your income tax return.

No person may be covered as both an Employee and a Dependent under the Plan, and no person may be covered as a Dependent of more than one Employee.

Enrollment and Effective Date of Coverage.

Coverage in the Plan isn't automatic. You will receive information from the Employer about enrollment for benefits.

The Plan options you are eligible for will be listed on your enrollment form. Your enrollment:

- indicates your enrollment decisions for the Plan Year; and
- allows the Employer to deduct contributions from your pay.

Annual Open Enrollment Period.

You will be notified of the annual Open Enrollment Period, which is the one and only time in the year when you can change your health plan election and add or drop dependents without a Qualifying Election Change Event. Enrollment starts before the beginning of the Plan year. The coverage you choose goes into effect on the first day of the Plan Year and stays in effect through the last day of the Plan Year. Your annual enrollment materials will let you know if your election will remain the same or will default to another similar option in the next year if you don't change your elections.

Notify the Employer if your marital status changes during the Plan year or if you have another Qualifying Election Change Event that would permit you to change your election(s). Your Dependents must be enrolled within 30 days after they are first eligible for coverage or they will be considered "late enrollees" and ineligible to enroll until the next annual Open Enrollment Period. For example, "first eligible for coverage" means:

- Newborn—date of birth; and
- Spouse—date of marriage.

If You Move.

If you move from a location where you participated in the Plan to a location that is not eligible for this Plan or does not have a Network, you will be able to enroll in another Employer health plan. If you move, you must notify the Employer within 30 days so your records can be updated. Once your address has been changed internally, you will receive information about how to re-enroll in the health plan available in your area.

HIPAA Special Enrollment Rights.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage and you later lose eligibility for that coverage (or if the employer stops contributing toward your or your Dependents' other coverage), you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you and/or your dependents are covered under Medicaid or a state Child Health Insurance Program (CHIP) and lose eligibility for such coverage, you may be able to enroll yourself or your dependents who lost such coverage in a health insurance Program, provided that you request enrollment within 60 days after the loss of coverage. Likewise, if you and/or your Dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself or your Dependents who become eligible for premium assistance in a health insurance Program, provided that you request enrollment within 60 days after the date you are determined to be eligible for premium assistance. If your dependent child is receiving Medicaid or CHIP premium assistance toward the cost of plan benefits, you may also be able to disenroll the child from the Plan and enroll the child in and receive child health assistance under the state child health plan, effective on the first day of any month for which the child is eligible for premium assistance, to the extent required by law.

When Coverage Ends.

Coverage for you and your dependents ends on the earliest of the following:

- In the case of your death, on the date of your death;
- The last day of the month in which your employment ends;
- The last day of the month in which you exhaust your right to continued coverage during a leave of absence;
- The last day of the month in which you otherwise cease to be an Eligible Employee;
- The last day of the month in which your Dependent child turns age 26;
- If you are covered as a Spouse and you lose eligibility due to a legal separation, divorce or your marriage being annulled, your Coverage will end the last day of the month in which the legal separation, divorce, or annulment occurs.
- The last day of the month in which your Spouse or other Dependent otherwise ceases to be an eligible Dependent;
- At the end of the period for which contributions have been paid, if you fail to make further contributions or you cancel

your payroll deduction authorization;

- The date a covered Participant ceases to maintain full time residency in the United States of America or Canada, or no longer lives in the Plan's service area if the Plan requires residency in a service area;
- On a date, as determined by CDPHN and the Plan Administrator, that you or your family member intentionally provided false information or made misrepresentations in connection with a claim for benefits; or permitted a non-Participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits under the Plan; or obtained or attempted to obtain benefits by reason of false, misleading or fraudulent information, acts or omissions; or failed to make any Copayment, supplemental charge, or other amount due with respect to a benefit under the Plan; or behaved in a manner disruptive, unruly, abusive, or uncooperative to the extent that the Plan is unable to provide benefits to you or your family members; or threatened the life or well-being of personnel administering the Plan or of Providers of services or benefits; or
- The date the Plan is terminated.

Coverage for a Dependent can terminate sooner if the Dependent becomes an Eligible Employee under the Plan.

Some (but not all) of the events that cause coverage to terminate will allow you and/or your Dependents, as applicable, to elect "COBRA" coverage for a period of time. Refer to the Sections on *Termination of Coverage* and *COBRA* for more information.

Note: Once an individual is covered under the Plan, coverage can be rescinded (i.e., terminated retroactively) only under limited circumstances. For example, coverage can be rescinded if the individual performs an act, practice or omission that constitutes fraud or intentionally misrepresents a material fact. If this happens, the Plan must provide at least 30 days advance written notice to each person who would be affected before coverage may be terminated. Coverage can also be terminated retroactively under certain circumstances permitted by the U.S. Department of Labor, including non-payment of premiums, or failure to report a dependent's loss of eligibility. These circumstances are not considered rescissions requiring 30 days advance written notice.

SECTION FOUR—Deductibles and Maximums

Deductibles

Annual Deductible.

The annual Deductible applies to certain Covered Services and is the initial amount that must be paid by a Participant before the Plan pays any Benefits. Once the applicable annual Deductible is paid, the Plan begins to pay Benefits for all Covered Services. The Deductible starts over **each** Calendar Year—thus the name **annual** Deductible.

Not all benefits are subject to the Deductible. The Plan provides benefits for certain Covered Services, like Preventive Care, even you have not met the annual Deductible. See the Plan's Summary of Benefits and Coverage and the *Schedule of Benefits* for information on which Covered Services are subject to the Deductible.

Individual and Family Deductibles

If you are enrolled in Single Coverage, then the Individual Deductible is the initial amount you must pay out-of-pocket for Covered Services before the Plan begins paying Benefits. Once your out-of-pocket expenses for Covered Services reach the Individual Deductible amount for the year, the Plan begins to pay Benefits for Covered Services.

If you have a level of Plan Coverage higher than Single Coverage (e.g., Employee +1, Family, etc.), then the annual Individual Deductible applies separately to **you and each of your Dependents** covered by the Plan. Once a Participant's Individual Deductible is met in a year, no further Deductibles will be taken for that Participant during that year. Once the Family Deductible dollar maximum has been met, however, the Plan begins paying benefits for Covered Services for all family members who are Participants for the remainder of the year, including those that may not have met their Individual Deductible.

Notes:

- Participant Copayments for Covered Services are not credited toward the Deductible.
- Participant payments for services that are not Covered Services are not credited toward the Deductible.
- Participant payments for Covered Services in excess of the Allowed Charge are not credited toward the Deductible.
- Precertification penalties are not credited toward the Out-of-Pocket Maximum.
- In-Network Preventive Care is not subject to the Deductible.
- If a person covered by the Plan changes status from Subscriber to Dependent or Dependent to Subscriber and the person is covered continuously under this Plan during the Plan Year, credit will be given for amounts paid toward the Deductible and all amounts applied to Out-of-Pockets Maximums.

Out-of-Pocket Maximums

Annual Out-of-Pocket Maximums.

Your out-of-pocket payments for Copayments, Deductibles, and Coinsurance apply to the Out-of-Pocket (OOP) Maximum. When such out-of-pocket expenses for Covered Services reach the annual OOP Maximum, the Plan pays subsequent Covered Services in full for the remainder of the Calendar Year, as further explained below.

Individual and Family OOP Maximums

If you are enrolled in Single Coverage, then the Individual Out-of-Pocket Maximum is the amount you must pay out-of-pocket for Covered Services before the Plan begins paying Benefits in full for Covered Services for the rest of the year. Once your out-of-pocket expenses for Covered Services reach the Individual Out-of-Pocket Maximum amount for the year, the Plan begins to pay Benefits in full for Covered Services.

If you have a level of Plan Coverage higher than Single Coverage, (e.g., Employee +1, Family, etc.) then the annual Individual Out-of-Pocket Maximum applies separately to **you and each of your Dependents** covered by the Plan. Once a Participant's Individual Out-of-Pocket Maximum is met in a year, that family member will have no further out-of-pocket expenses for Covered Services for the remainder of that year. Once the Family OOP Maximum has been met, however, the Plan pays Benefits in full for subsequent Covered Services for all family members for the remainder of the year—even if all members of the family have not yet met their Individual OOP Maximum. The Family OOP Maximum may be met by any combination of one or more family members' OOP expenses. However, no single family member may contribute more than $3,000 toward meeting the Family Out-of-Pocket Maximum.

Note: The Out-of-Pocket Maximum includes both Medical and Pharmacy deductibles, copayments, and coinsurance.

SECTION FIVE—Inpatient Care

Medical Services While Hospitalized.

Benefits for Medically Necessary medical services while hospitalized due to Injury, Illness, or pregnancy, including hospital visits, consultations, surgical operations, radiology, pathology, anesthesiology, chemotherapy, and inhalation therapy will be provided. Surgical operations include reconstructive surgery when such surgery is incidental to or following surgery resulting from trauma, infection, or other diseases of the part of the body involved, and reconstructive surgery performed on a covered dependent child because of a congenital disease or anomaly, which has resulted in a functional defect. Coverage is provided for breast reconstruction surgery after a mastectomy for all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined to be appropriate by the attending Physician and the patient. CDPHN Resource Coordination Prior Authorization is required. Benefits for Mental Health Conditions or Chemical Dependency care in facilities licensed to provide residential treatment are covered.

Inpatient Services Under the Plan.

During any period of inpatient hospitalization for which Coverage is provided under the Plan, you also will be entitled to benefits for the services of your Primary Care Physician, or another Participating Provider to whom you are Referred by your PCP—if your admission was authorized by your PCP. If your admission was not authorized by your PCP, services are not covered.

In-Network Services by non-Participating Providers.

In the event the Covered Services cannot be provided by a Participating Provider or Practitioner, such services are available from a non-Participating Provider or Practitioner. To be covered as In-Network, such services must be authorized in advance and approved in writing by the CDPHN Medical Director or his/her designee, prior to the services being rendered. The services provided will be subject to the limitations and exclusions of the Plan. Services rendered by non-Participating Practitioners or Providers without prior written approval by CDPHN Medical Director, or his/her designee, will be considered Out-of-Network Services, except for necessary Emergency Care as described in Section Thirteen—Emergency Care.

Services Not Covered.

The Plan will not provide Benefits for the following services in a Hospital:

- Special duty nurses, unless in the sole judgment of the CDPHN Resource Coordination Department, private duty nurses are Medically Necessary for your condition;
- Private room, unless in the sole judgment of the CDPHN Resource Coordination Department, a private room is Medically Necessary for your condition. If you occupy a private room without authorization, you will have to pay, in addition to the applicable Copayment or Deductible and Coinsurance, the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations;
- Non-medical items or services, such as television rental or barber service.

Medical Necessity and Prior Authorization for Inpatient Care.

Admission to a hospital must be preauthorized by CDPHN Resource Coordination.

Subject to any limitations on the number of days of inpatient care described below, benefits will be provided for any day the CDPHN Resource Coordination Department determines that hospitalization was Medically Necessary for the care or treatment of your condition, Illness, or Injury.

Inpatient hospital maternity care is automatically covered for at least 48 hours after childbirth for any delivery other than a cesarean section, and for at least 96 hours after cesarean section. You have the option to be discharged earlier than the 48 or 96 hours.

Benefits will not be provided after a date the CDPHN Resource Coordination Department determines that hospitalization no longer was Medically Necessary.

Inpatient Rehabilitation

The Plan provides coverage for inpatient substance abuse services relating to the diagnosis and treatment of alcoholism, substance abuse and dependency received at facilities that provide inpatient care and residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASIS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such facilities in accordance with 14 NYCRR parts 817 and 819; and, in other states, to those facilities that are licensed or certified by similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment. See the Schedule of Benefits for inpatient and outpatient alcohol and substance abuse benefits. Benefits must be coordinated through the CDPHP Behavioral Health Access Unit 1-888-320-9584.

SECTION SIX—Outpatient Care

Office Visits.

The Plan will provide In-Network benefits for office visits to your Participating Practitioner (physician or specialist)—including clinic visits billed by a hospital for treatment of Illness, disease and Injury.

The Plan does not provide Out-of-Network benefits for office visits and services of a non-Participating Practitioner (physician or specialist).

Outpatient Facilities.

The Plan will provide In-Network benefits for outpatient facilities charges by a Participating Provider.

SECTION SEVEN—Infertility Treatment and Services

Infertility services are covered by the Plan as follows:

Infertility Treatment Overview

Services and supplies for the care and treatment of infertility, including artificial insemination, shall be payable as specified in the *Schedule of Benefits*.

Benefits shall be payable for the evaluation and investigation of the cause of male or female primary infertility. Once a diagnosis has been established, benefits for the treatment of infertility will be allowed for the following:

- Advanced Infertility Services covers 3 cycles of IVF per lifetime, sperm storage costs in connection with IVF and cryopreservation and storage of embryos in connection with IVF.
- One ultrasound per course of treatment to determine follicle development
- One semen analysis

The following services and supplies are not covered by the plan:

- Ovulation predictor kits
- Charges and supplies related to surrogate maternity care
- Reversal of tubal ligation or vasectomy
- Charges related to egg or sperm/semen donation (active or frozen)
- In-vitro fertilization

Covered Services

Benefits are provided for the following services to support, confirm or treat a diagnosis of infertility when the services are performed by a qualified practitioner. This list contains examples of covered services and is not considered to be all inclusive (please contact CDPHP at the phone number listed on your ID Card for additional information):

- Artificial insemination
- Blood tests
- Endometrial biopsy
- History and physical examination
- Hysterosalpingogram
- Hysteroscopy
- Laparoscopy
- Post-coital testing
- Semen analysis
- Sono-hysterogram
- Testis biopsy
- Ultrasound
- Pharmacological therapy

SECTION EIGHT—Gender Re-assignment

Gender re-assignment includes sexual reassignment surgery, mastectomy/chest reconstruction surgery, behavioral health therapy and hormone therapy as determined by the Claims Administrator in accordance with the World Professional Association for Transgender Health (WPATH) standards of care. You must be age 18 or older, have persistent gender dysphoria and the capacity to make a fully informed decision.

SECTION NINE—Dental Services

Emergency Dental Care.

The Plan will provide Emergency care immediately following trauma to sound, natural teeth consisting of trauma care, reduction of swelling, and pain relief, when authorized by your Primary Care Physician.

Accidental Dental Care.

The Plan provides benefits for dental service rendered by a physician or dentist required as a result of an accidental Injury that occurs to sound natural teeth that have been damaged or a fractured or dislocated jaw requires setting. The service must be rendered within 12 months of the accident, except when prior approved by CDPHN's Medical Director or his/her designee for Participants whose future growth prohibits necessary treatment from being performed within 12 months of the accidental Injury. Initial diagnosis of trauma must be diagnosed within 72 hours of the accidental Injury.

Services include:

- Full or partial dentures if needed.
- Fixed bridgework if needed.
- Prompt repair to natural teeth if needed.
- Appliances and splints placed on or attached to the teeth.

Inpatient hospital charges required for dental care not otherwise covered are eligible if Medically Necessary due to a Life-Threatening Illness, Injury, or disease. CDPHN Resource Coordination prior authorization is required.

Treatment needed due to a congenital disease or anomaly

The Plan also covers Medically Necessary dental services needed to correct a congenital disease or anomaly which has resulted in a functional impairment.

Dental Services

The Plan will not provide benefits for treatment for cavities and extractions, care of the gums or bones supporting the teeth, treatment of periodontal abscess, orthodontia, false teeth, orthognathic treatment and surgery, or any other dental services you may receive.

Removal of Impacted Teeth

Notwithstanding any language to the contrary elsewhere in this section, removal of Impacted Teeth and associated anesthesia charge is covered for all plan participants, regardless of age. CDPHN Resource Coordination prior authorization required. Benefits are payable based on location. This benefit is covered when performed by either an oral surgeon (medical) or dentist (dental).

SECTION TEN—Emergency Care

All Emergency care is subject to review for medical necessity.

The Plan urges Participants and their covered dependents to contact their Primary Care Physician for non-Emergency care. The Plan discourages the use of the hospital Emergency room for non-Emergency situations.

Additional Emergency care considerations.

The Plan covers Emergency outpatient care at the Emergency room of a Short-term, Acute-Care General Hospital or inpatient care in a Short-term, Acute-Care General Hospital. If the CDPHN Resource Coordination Department determines that your condition qualified for Emergency care, your care and treatment provided by non-participating facilities and providers will be covered at the in-network level.

- **Length of Stay in a Hospital.** The Plan provides care in the hospital only for as long as your Physician determines that the hospitalization was Medically Necessary or that your medical condition prevented your transfer to another hospital designated by CDPHN.
- **Dental Services.** The Plan will provide Emergency care immediately following trauma to sound, natural teeth consisting of trauma care, reduction of swelling, and pain relief:, when authorized by your Primary Care Physician.
- **Exclusions.** Emergency benefits cover sudden onset of life-threatening Illness or Injury in the CDPHN service area or out of the service area. However, the Plan will not pay for Emergency care outside of the CDPHN service area in the following situations: care you could have foreseen before leaving the CDPHN service area; follow-up services (to Emergency care) that can be delayed until you return to the CDPHN service area without damage to your health.

Ambulance Service.

The Plan will provide benefits for Medically Necessary transportation by ambulance to the nearest facility qualified to provide the required treatment. Ambulance services must be Medically Necessary resulting from an emergency or used for non-emergency inter-facility transport. If, in the judgment of the CDPHN Resource Coordination Department emergency transport by ambulance was required, benefits will be provided in accordance with the Schedule of Benefits.

Note: Certain non-Network ambulance services, if provided by the emergency department of a hospital, will also be covered at In-Network rates where required by law.

Payments for Emergency care within the service area or outside the service area.

You are entitled to medically appropriate Emergency care at an Emergency room of a hospital, regardless of geographic location. Facility emergency services are covered in full after payment of the applicable cost sharing in the Schedule of Benefits. No referral is required. Physician (professional) Emergency services are Covered in Full.

Services that are not Medically Necessary are not covered. (Nor are any services related to a non-covered service covered.)

SECTION ELEVEN—Home Health Care

Conditions for Home Health Care.

Under the Plan, benefits will be provided for home health care visits authorized by your CDPHN Primary Care Physician with Prior Authorization from the CDPHN Resource Coordination Department, when the following conditions are met:

- You are home bound because of medical reasons.
- The home care service is Medically Necessary as determined by your Primary Care Physician.
- There is a defined medical goal that you are expected to obtain as a result of the provision of home care services.

Prior Authorization

Prior Authorization from CDPHN Resource Coordination is required. If prior authorization is not obtained, benefits will be denied.

Personnel Providing Home Health Care.

Home care will be provided by Home Health Care Agency Personnel. Benefits will be paid only if the Agency is licensed or certified as a Home Health Care Agency under the laws of the state in which it is located.

Home Health Care Services Provided.

The Plan will provide benefits for the following home health care services:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide services that consist primarily of caring for you;
- Physical, occupational, or speech therapy, if provided by a participating Provider or Home Health Care Agency;
- Medicines, surgical supplies, drugs, and dressings furnished in connection with a visit by a participating Provider or Home Health Care Agency personnel;
- Medical social services if provided by a participating Provider or Home Health Care Agency personnel; and
- Lab services.

Number of Home Health Care Visits.

Benefits will be provided on any day your Primary Care Physician or CDPHN Medical Director determines that (i) home care was Medically Necessary for the care or treatment of your condition, Illness, or Injury, and (ii) if you did not receive home care you would have to be hospitalized in a Short-Term, Acute-Care General Hospital. Four hours of home health aide care shall be considered as one home care visit. Visit limits, if any, appear in the *Schedule of Benefits*.

SECTION TWELVE—Skilled-Nursing Facility Care

Benefits will be provided in accordance with the Schedule of Benefits for care in a skilled-nursing facility when the admission is authorized by your Primary Care Physician and complies with the requirements below:

Type of Skilled-Nursing Facility.

The Plan will provide benefits only in a skilled-nursing facility that meets the following requirements:

- It is accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Health Care Organizations, and
- It is certified as a skilled-nursing facility under Medicare.

Prior Authorization

Prior Authorization from CDPHN Resource Coordination is required. If prior authorization is not obtained for, benefits will be denied.

Number of Days of Care.

Benefits will be provided in a semi-private room, on any day the CDPHN Resource Coordination Department determines that confinement in a skilled-nursing facility is Medically Necessary for the care or treatment of your Illness, disease, or Injury. Benefits will not be provided after the date the CDPHN Resource Coordination Department determines that confinement no longer is Medically Necessary. Maximum day limits, if any, appear in the Schedule of Benefits.

SECTION THIRTEEN—Hospice Care

Hospice care is care provided to terminally ill patients at home or in home-like facilities by a hospice organization licensed by the state in which it is located. The services provided by hospice must be Medically Necessary and appropriate for the care of the patient. Care may consist of inpatient or outpatient services. All services must be billed by the hospice organization. Benefits will be provided as described in the Schedule of Benefits.

Eligibility for Benefits.

To obtain benefits for hospice care under the Plan, the covered individual must meet the following conditions:

- He or she must experience an Illness for which the attending physician's prognosis for life expectancy is estimated to be six months or less.
- Palliative care (pain control and symptom relief) rather than curative care is considered most appropriate.
- The covered individual's admission to the hospice organization must be authorized by his or her Physician.
- Inpatient hospice services require CDPHN resource coordination prior authorization.

Hospice Care Benefits.

The Plan will pay for the following services when provided by the hospice organization:

- Bed patient care either in a designated hospice unit or in a regular hospital bed;
- Day care services provided by the hospice organization;
- Home care and outpatient services that are provided by the hospice organization and for which the hospice organization charges you;
- Bereavement counseling (up to five family visits either before or after terminally ill member's death) for the patient and the immediate family by a licensed social worker or licensed pastoral counselor.

Prior Authorization.

Prior Authorization from CDPHN Resource Coordination is required. If prior authorization is not obtained for Participating Providers, benefits will be denied.

Number of Days of Care.

Benefits will be provided on any day the CDPHN Resource Coordination Department determines that Hospice Care is Medically Necessary for the care of your Illness, disease, or Injury. Maximum day limits, if any, appear in the Schedule of Benefits.

SECTION FOURTEEN—Private Duty Nursing

Under the Plan, benefits will be provided in accordance with the Schedule of Benefits for private duty nursing care in your home when Medically Necessary, on any day your Physician determines, in conjunction with the CDPHN Resource Coordination Department, that such care is Medically Necessary for the treatment of your Illness, disease, or Injury.

Personnel Providing Private Duty Nursing.

The private duty nursing care must be provided by a registered professional nurse or a licensed practical nurse that is registered in and/or licensed by the state in which such person practices. Benefits will not be provided for private duty nursing rendered by a person who ordinarily resides in your home or one who is a member of your immediate family (i.e., parent, spouse, brother, sister, or child).

Prior Authorization

Prior Authorization from CDPHN Resource Coordination is required. If prior authorization is not obtained for, benefits will be denied.

Number of Days of Care.

Benefits will be provided on any day the CDPHN Resource Coordination Department determines that Private Duty Nursing is Medically Necessary for the care of your Illness, disease, or Injury. Maximum day limits, if any, appear in the Schedule of Benefits.

SECTION FIFTEEN—Outpatient Therapy Services

The Plan provides Outpatient Therapy Services as follows when ordered by your PCP:

- **Speech Therapy:** The Plan provides coverage for services provided by a licensed speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness, Injury, surgery and or congenital anomaly to the maximum benefit, on an outpatient basis. CDPHN Resource Coordination Prior Authorization required after the initial evaluation.
- **Occupational Therapy:** The Plan provides coverage for services provided by a licensed occupational therapist for occupational therapy to the maximum benefit, on an outpatient basis.
- **Physical Therapy:** The Plan provides coverage for services provided by a licensed physical therapist for physical therapy to the maximum benefit, provided services are ordered by a physician.
- **Chiropractic:** The Plan provides coverage for services provided or prescribed by a licensed chiropractor, for manual manipulation of the spine or related services (including laboratory tests, X-rays, and chiropractic appliances) to treat subluxation of the spine and supporting structures or other Neuromusculoskeletal Disorder. Manual devices may be used but there is no additional payment for use of the device or for the device itself.
- **Acupuncture:** The Plan provides coverage for needle acupuncture (manual or electroacupuncture), to the maximum benefit of 15 visits per calendar year.

Prior Authorization.

Prior Authorization from CDPHN Resource Coordination is required for Speech Therapy after the initial evaluation. If prior authorization is not obtained for Participating Providers, benefits will be denied.

Number of Days of Care.

Maximum visit limits, if any, appear in the Schedule of Benefits. Additional benefits may be available, if upon review, a CDPHN Medical Director determines the requested visits meet medical necessity. Once the maximum therapeutic benefit has been achieved and functional status has remained stable for a given condition, without expectation of additional objective clinical improvements, further treatment is considered maintenance therapy and not Medically Necessary.

SECTION SIXTEEN—Podiatry

Podiatric Services.

The plan provides coverage for surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, treatment of bunions, fractures and dislocation of the bones of the feet. Routine care of the feet is not covered.

SECTION SEVENTEEN—Durable Medical Equipment, Prosthetic Appliances, and Hearing Aids

The Plan will provide benefits for durable medical equipment, prosthetic appliances, and orthotics described below in accordance with the Schedule of Benefits when they are prescribed by a participating provider.

Durable Medical Equipment, Prosthetic Appliances, Orthotics.

The use of the equipment/appliance must be directly related to the treatment of your condition. Durable medical equipment is equipment that is intended for repeated use and is not generally useful to a person in the absence of Illness or Injury. The equipment must be of a kind that generally is used only to treat a medical condition. The equipment will generally be rented unless the CDPHN Resource Coordination Department determines that it is less expensive to purchase. See the *Exclusions* section for more detail. Supplies included in the rental or purchase fee are covered. Coverage is provided for standard equipment only.

The items the Plan *will pay for* include, but are not limited to, oxygen and oxygen equipment, a non-motor driven wheelchair, hospital bed, braces or crutches. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered, nor are repairs that would be covered a manufacturer's warranty or purchase agreement.

Items the Plan *will not pay for* include, but are not limited to, deluxe equipment (such as a motor-driven wheelchair) when standard equipment is available and medically adequate, items not medical in nature, comfort and convenience items, disposable supplies (other than bandages and dressings), exercise and hygiene equipment, sauna bath, air conditioners, humidifiers and dehumidifiers, experimental or research equipment, and electronic communication devices.

Orthotics.

Orthotic Devices are rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. CDPHN will provide Coverage for the purchase of Medically Necessary orthotic devices subject to the same criteria as set forth in DME coverage above. There is no Coverage for orthotic shoe inserts.

Prosthetic Appliances.

The Plan will pay for prosthetic appliances the uses of which are directly related to the treatment of your condition. **Prosthetic Devices** are devices which replace all or part of a body organ, or replace all or part of a permanently inoperative, absent or malfunctioning body part, including but not limited to, artificial limbs, eyes, post-mastectomy breast prostheses, and post-laryngectomy prosthetics. The Plan will provide Coverage for the purchase of a particular prosthetic device once during a member's lifetime, subject to the Plan's repair, replacement and maintenance policy.

Items the Plan *will not pay* for also include, but are not limited to: any appliance or device that could be used by any other member of your family or person with your condition, arch supports, corrective shoes, wigs, hair prosthetics, experimental or research appliances or devices, electronic communication devices, and dental prosthetics, except in connection with accidental Injury to sound natural teeth as provided in *Outpatient Care*.

Hearing Aids.

Not covered.

Oxygen.

Medically Necessary oxygen is Covered, subject to the same criteria as set forth for DME, Orthotics, and Prosthetics above.

Diabetic DME Services.

Diabetic DME—Medically Necessary Durable Medical Equipment such as injection aids, insulin pumps, glucometers and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors (including non-invasive, subcutaneous or monitor implants) and blood glucose monitors for the legally blind are covered. CDPHN Resource Coordination Pre-authorization required. (Certain equipment and/or devices may not be subject to the prior authorization requirement.)

Diabetic Pharmaceuticals—Includes Insulin and oral agents for controlling blood sugar. Must be obtained through a pharmacy and paid in accordance with the terms applicable to Prescription Drug Benefits.

Diabetic Supplies—Includes test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, insulin pump supplies, and cartridges for the legally blind. Paid in accordance with the terms applicable to Prescription Drug Benefits.

Diabetic Education—Diet and/or self-Management education provided by the physician or his/her staff as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician.

Prior Authorization.

CDPHN resource coordination prior authorization is required for all rentals, and for purchase of items over $1000. If prior authorization is not obtained for Participating Providers, benefits will be denied.

SECTION EIGHTEEN—Mental Health Care and Substance Use Services

Please refer to the *Schedule of Benefits* for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Mental Health Care Services.

Inpatient Services.

The Plan covers inpatient services relating to the diagnosis and treatment of Mental Health Conditions comparable to other similar Hospital, medical and surgical coverage provided under the Plan. Coverage for inpatient services to treat Mental Health Conditions in New York is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and, in other states, to similarly licensed or certified Facilities. The Plan also covers inpatient services relating to the diagnosis and treatment of Mental Health Conditions received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment.

Outpatient Services.

The Plan covers outpatient services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Conditions. Coverage for outpatient services for treatment of Mental Health Conditions includes facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst;: a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage.

The Plan does not cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court (unless Medically Necessary and approved by the Plan).

Substance Use Services.

Inpatient Services.

The Plan covers inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also covers inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services.

The Plan covers outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence

treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Plan that covers the Participant receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION NINETEEN—Transplants

Transplant Services.

The Plan covers only those transplants determined not to be Experimental and Investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by an appropriate specialist and performed at a Hospital specifically approved by CDPHN to perform these procedures.

The Plan covers the Hospital and medical expenses, including travel expenses, of the Participant-recipient. The Plan covers transplant services required by Participants serving as an organ donor only if the recipient is also a Participant. The Plan does not cover the medical expenses of a non-Participant acting as a donor for the Participant if the non-Participant's expenses will be covered under another health plan or program.

The Plan does not cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

Prior Authorization.

CDPHN resource coordination Prior Authorization is required for all transplants. If prior authorization is not obtained, benefits will be denied.

SECTION TWENTY—Vision Care

Vision care is not covered by the Plan.

SECTION TWENTY-ONE—Preventive Care

The Plan provides free Preventive Care In-Network in accordance with the requirements of the ACA. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The Plan will be automatically updated each year to add any new required Preventive Services mandated by the Affordable Care Act as of the required effective date for each Preventive Service. Therefore, the Plan's Preventive Care Services are described in a separate booklet titled Preventive Care Benefits, available oe at www.CDPHP.com. To request a copy or to learn more about what this Plan covers, call the Customer Service number on your ID Card.

SECTION TWENTY-TWO—Coverage During Clinical Trials

The Plan will not deny a Plan Participant who is eligible, according to the trial protocol, to participate in an approved Clinical Trial for the treatment of cancer or another life-threatening condition and either:

- the referring health care professional is a participating Provider and has concluded that the Participant's participation in the Clinical Trial would be appropriate; or

- the Participant provides medical and scientific information establishing that the individual's participation in the Clinical Trial would be appropriate.

The Plan will not deny, limit or impose additional conditions on the coverage of routine patient costs (e.g., items and services typically provided for a patient *not* enrolled in an approved Clinical Trial) for items and services associated with participation in the approved Clinical Trial. However, such items and services do not include:

- the investigational item, device or service itself;
- items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or
- a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

The Plan reserves the right to require use of a Participating Provider participating in an approved Clinical Trial if the Participating Provider will accept you as a participant. The Plan will not discriminate against any qualified individual who participates in an approved Clinical Trial.

SECTION TWENTY-THREE—Case Management Program

The Plan's Medical Management team consists of Case Managers who are registered nurses. Case Managers work with members who have complicated medical conditions that require ongoing care and with members who are admitted to the Hospital.

When you call the Administrative Agent to precertify a Hospital admission, you may be assigned a Case Manager. The Case Manager will work with you, your family and your Provider to ensure you receive the care you need during your Hospital stay and after discharge—such as home care or physical therapy.

Case Managers are assigned to members who the Administrative Agent believes will benefit from such services. However, if you feel as though you have a condition for which a Case Manager would be helpful, you may call Member Services to request a Case Manager.

Precertification Provisions

You must precertify all scheduled Hospital admissions before admission. In addition, you must precertify certain other services. If you use an in-network provider or facility, your provider will complete the precertification process for you. If you are using out-of-network providers or facilities, then you must obtain the precertification yourself.

All scheduled Hospital stays must be approved by the Administrative Agent before admission. Your stay cannot extend past the originally scheduled number of days unless the extension is pre-approved by the Administrative Agent. You must call Member Services to precertify your care for the following out-of-network admissions and/or services:

- before any scheduled in-patient Hospital admission;
- before you extend your Hospital stay beyond the original number of approved days;
- for acute inpatient rehabilitation;
- before any organ transplant;
- for home infusion therapy; and
- before inpatient maternity care.

You also must notify Member Services within two business days of any Emergency Hospital admission (including maternity).

Failure to comply with the above precertification requirements will result in a $500 penalty.

Inpatient maternity admissions will be approved consistent with the Newborns' and Mothers' Health Protection Act of 1996. Providers need not obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). Failure to precertify out-of-network maternity admissions may result in a $500 penalty.-

You must also precertify out-of-network home health care, Hospice Care and Skilled Nursing Facilities. **If you do not do so, your claim will be denied.**

SECTION TWENTY-FOUR—Schedule of Benefits—EPO $250

Benefit	Domestic Network (All Saratoga Hospital Owned Facilities and Providers)	Non-Domestic Network (CDPHN local and National MagnaCare and First Health Participating Facilities and Providers)
Annual deductible	Not Applicable	Individual $250 2-Person and Family $500
Out of Pocket Maximum Annual out-of-pocket maximum includes both medical and pharmacy deductibles, copayments, and coinsurance	Not Applicable	Individual $2,000 2-Person and Family $4,000
Lifetime Maximum— All Covered Benefits	Unlimited Per Covered Member	Unlimited Per Covered Member
Lifetime Maximum—Durable Medical Equipment, Orthotics, Prosthetics & Oxygen	Unlimited Per Covered Member	Unlimited Per Covered Member
Annual Maximum—All Covered Benefits	Unlimited Per Covered Member	Unlimited Per Covered Member
Primary Care Office Visit Copayment	Covered in Full	$30 Copayment
Specialty Care Office Visit	Covered in Full	$40 Copayment
Office or Outpatient Hospital Based Health Services Only one visit Copayment will be required per provider per day Covered Services		
Primary Care Office and Home Visits	Covered in Full	$30 Copayment
One primary care routine physical exam per benefit period	Covered in Full	Covered in Full
One routine gynecological physical exam per benefit period	Covered in Full	Covered in Full
All other gynecological physical exams.	Covered in Full	$40 Copayment
Diagnostic Services: Radiology and imaging, including (but not limited to): X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs and CT Scans	Covered in Full	$150 Copayment
Mammograms—One routine mammogram per calendar year.	Covered in Full	Covered in full
Bone Mineral Density Measurements and Tests	Covered in Full	Covered in full if billed as preventive
Cervical Cytology Screenings	Covered in Full	Covered in Full
Well Child Visits Frequency Guidelines: Coverage for visits at 2 weeks; 1 month; 2, 4, 6, 9, 12, 15 and 18, 24 & 30 months. Also one visit per calendar-year ages 3 to 19. Any other visits as recommended by the American Academy of Pediatrics.	Covered in Full	Covered in Full
Obstetrical Services	Covered in Full	$30 PCP/OBGYN
Immunizations	Covered in Full	Covered in full if billed as preventive

SECTION TWENTY-FOUR—Schedule of Benefits—EPO $250 *(continued)*

Benefit	Domestic Network (All Saratoga Hospital Owned Facilities and Providers)	Non-Domestic Network (CDPHN local and National MagnaCare and First Health Participating Facilities and Providers)
Office or Outpatient Hospital Based Health Services Only one visit Copayment will be required per provider per day Covered Services		
Allergy Tests	Covered in Full	$30 PCP/$40 Specialist if rendered in the office Deductible then 20% coinsurance if rendered by in an outpatient facility setting
Allergy Injections	Covered in Full	$30 PCP/$40 Specialist if rendered in the office Deductible then 20% coinsurance if rendered by in an outpatient facility setting
Nutritional Counseling	Covered in Full	$30 PCP/$40 Specialist
Surgical Procedures when performed in the office	Covered in Full	$30 PCP/$40 Specialist Copayment
Anesthesia	Not available in Domestic Network	$30 PCP/$40 Specialist Copayment if rendered in the office Deductible then 20% coinsurance if rendered in an outpatient facility setting
Chiropractic Services	Not available in Domestic Network	$40 Specialist Copayment
Standard diagnostic testing for prostatic cancer	Covered in Full	Covered in full
Medication management rendered by a Participating Practitioner psychiatrist	Covered in Full	$30 Copayment
Neuropsychological testing related to a medical Diagnosis and rendered by a Participating Practitioner	Not Available in Domestic Network	$30 PCP/$40 Specialist Copayment
Chemotherapy	Covered in Full	$30 PCP/$40 Specialist Copayment if rendered in the office Deductible then 20% coinsurance if rendered by in an outpatient facility setting
Radiation Therapy	Covered in Full	$30 PCP/$40 Specialist Copayment if rendered in the office Deductible then 20% coinsurance if rendered by in an outpatient facility setting
Urgent Care Services	Covered in Full	$75 Copayment
Second Surgical/Medical Opinions	Covered in Full	$30 PCP/$40 Specialist Copayment
Physical Therapy	Covered in Full	$40 Specialist Copayment
Occupational Therapy	Covered in Full	$40 Specialist Copayment
Speech Therapy	Covered in Full	$40 Specialist Copayment

SECTION TWENTY-FOUR—Schedule of Benefits—EPO $250 *(continued)*

Benefit	Domestic Network (All Saratoga Hospital Owned Facilities and Providers)	Non-Domestic Network (CDPHN local and National MagnaCare and First Health Participating Facilities and Providers)
Laboratory Services		
Office Based Laboratory Services	Covered in Full	Deductible then 20% coinsurance
Outpatient Hospital Based Laboratory Services	Covered in Full	Deductible then 20% coinsurance
Freestanding Facility Based Laboratory Services	Covered in Full	Deductible then 20% coinsurance
Inpatient Hospital Based Health Services		
Inpatient Hospital Service	Covered in Full	Deductible then 20% coinsurance
Newborn Nursery Care	Covered in Full	Deductible then 20% coinsurance
Maternity Care	Covered in Full	Deductible then 20% coinsurance (Prenatal and Postpartum Care Covered in Full as a preventive service)
Bariatric Surgery	Covered in Full	Deductible then 20% coinsurance
Skilled Nursing Facility Services	Covered in Full	Deductible then 20% coinsurance
Organ Transplant Services	Not Available in Domestic Network	Deductible then 20% coinsurance
Practitioners Services when billed separately by the provider, not by the facility.	Covered in Full	$30 PCP/$40 Specialist Copayment
Acute Short-Term Inpatient Rehabilitation Services	Covered in Full	Deductible then 20% coinsurance
Outpatient Hospital Surgery and Freestanding Ambulatory Surgery Facility Services		
Surgery and Use of Operating and Recovery Rooms	Covered in Full	Deductible then 20% coinsurance
Bariatric Surgery	Covered in Full	Deductible then 20% coinsurance
Infertility Advanced IVF		
Infertility Advanced IVF *Advanced Infertility Services covers 3 cycles of IVF per lifetime, sperm storage costs in connection with IVF and cryopreservation and storage of embryos in connection with IVF.	Not Available in Domestic Network	$30 PCP/$40 Specialist Copayment if rendered in the office Deductible then 20% coinsurance if rendered in an inpatient/outpatient facility setting
Infertility Fertility Preservation Services *Fertility preservation services are covered when a medical treatment (surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes) directly or indirectly leads to infertility.	Not Available in Domestic Network	$30 PCP/$40 Specialist Copayment if rendered in the office Deductible then 20% coinsurance if rendered in an inpatient/outpatient facility setting
Emergency Services		
Emergency Department Services	$100 Copayment (copayment waived if admitted)	$150 Copayment (copayment waived if admitted)
Professional Ambulance Services	Not Available in Domestic Network	$100 Copayment
Medically Necessary non-Emergency, non-airborne inter-facility transportation	Not Available in Domestic Network	$100 Copayment

SECTION TWENTY-FOUR—Schedule of Benefits—EPO $250 *(continued)*

Benefit	Domestic Network (All Saratoga Hospital Owned Facilities and Providers)	Non-Domestic Network (CDPHN local and National MagnaCare and First Health Participating Facilities and Providers)
Substance Use Disorder and Dependency Treatment Services		
Outpatient Substance Use Disorder Services	Not Available in Domestic Network	$30 Copayment
Inpatient Substance Use Disorder Detoxification Services	Not Available in Domestic Network	Deductible then 20% coinsurance (Benefits include coverage for Residential Treatment Centers)
Inpatient Substance Use Disorder Rehabilitation Services	Not Available in Domestic Network	Deductible then 20% coinsurance (Benefits include coverage for Residential Treatment Centers)
Mental Health Care Services		
Outpatient Services	Not Available in Domestic Network	$30 Copayment
Inpatient Facility Services	Covered in Full	Deductible then 20% coinsurance (Benefits include coverage for Residential Treatment Centers)
Partial Hospitalization	Not Available in Domestic Network	Deductible then 20% coinsurance
Medical Services		
Home Health Care Services	Not Available in Domestic Network	$40 Copayment
Durable Medical Equipment, Prosthetic, Orthotic Devices and Oxygen	Not Available in Domestic Network	Deductible then 20% coinsurance
Hospice Care	Not Available in Domestic Network	Deductible then 20% coinsurance
Outpatient Dialysis Services	Not Available in Domestic Network	Deductible then 20% coinsurance
Access to End of Life Care	Not Available in Domestic Network	Deductible then 20% coinsurance
Diabetic Services		
Diabetic Durable Medical Equipment	Not Available in Domestic Network	$40 copayment
Diabetic Drugs & Supplies: 30-day Supply	$15 copayment (Non-Formulary drugs and supplies with prior authorization $55 copay)	$15 copayment (Non-Formulary drugs and supplies with prior authorization $55 copay)
Diabetic Drugs & Supplies: Mail Order	Not Available in Domestic Network	90-day supply for 2.5 copayments
Medically Necessary Self-Management Education	Covered in Full	$40 Copayment
Diabetic Eye Exam	Covered in Full	$40 Copayment
Prescription Drug Coverage		
Retail	Tier 1—$10 Tier 2—$40 Tier 3—$55	Tier 1—$10 Tier 2—$40 Tier 3—$55
Mail Order	Not Available in Domestic Network	90-day supply for 2.5 copayments

SECTION TWENTY-FIVE—Exclusions

The Plan does not cover:

- Act of War/Military Duty:
  - Act of War/Military Duty:
  - Any Injury or Illness resulting from a war, declared or not, or any military duty or any release of nuclear energy.
  - Subject to any secondary payor rules, charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
- Blood:
  - Blood, blood products, blood plasma, packed blood cells, and blood platelets, if there is no charge by the facility, or when they are available free of charge in the local area (except for the treatment of hemophilia when billed by a facility).
  - Storage of blood or blood products. This does not apply to autologous (one's own blood) blood donations. Benefits for transfusion services, including storage, for autologous donations of blood and blood components are available when associated with a scheduled, Covered Surgical Procedure.
- Cosmetic Surgery:
  - Non-Medically Necessary cosmetic services, including plastic surgery, and elective treatment for aesthetic improvement of nondisabling physical defects or problems. This exclusion shall not apply to a cosmetic operation when it is Medically Necessary, or reconstructive surgery when incidental to or when it 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 results in a functional impairment. Reconstructive surgery shall not include surgery for scar repair/revision only, where no functional defect is present. Requests for potentially cosmetic procedures and services will be subject to CDPHN's Utilization Review process including all avenues of appeals. Nothing herein shall be interpreted to preclude the application of Insurance Law § 4303 regarding breast reconstruction surgery after a mastectomy.
- Custodial/Convalescent Care:
  - Services for Custodial Care. Care is considered custodial when it is primarily for the purpose of helping the Participant with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. All requests for potentially custodial procedures and services will be subject to CDPHN's Utilization Review process including all avenues of appeals under the Plan.
  - Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
- Dental Services: Any dental care and treatment, except as explicitly provided elsewhere in this SPD. Examples of excluded services generally include the following:
  - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery;
  - Dental appliances;
  - Dental prostheses such as crowns, bridges, or dentures;
  - Implants;
  - Orthodontic care;
  - Operative restoration of teeth (fillings);
  - Extractions;
  - Endodontic care;
  - Apicoectomies;
  - Excision of radicular cysts or granuloma;
  - Treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; and
  - Any treatment of teeth, gums or tooth related service except otherwise specified as covered.
- Durable Medical Equipment, other Equipment and Devices:
  - Duplicate equipment or devices (e.g. one for home and one for school).
  - Repair or replacement of Durable Medical Equipment, prosthetic devices or orthotic devices due to loss, misuse or neglect.
  - Equipment or devices which serve as comfort or convenience items.

- Environmental control items including, but not limited to, air conditioners, humidifiers, dehumidifiers and/or air purifiers.
- Repairs of equipment or devices that are subject to manufacturer warranty.
- Charges related to the shipping, handling and/or delivery of Covered equipment or devices.
- Devices or equipment used primarily for the purpose of athletic activities or employment.
- Computer assisted communication devices or electronic communication devices that are not implanted into the body.
- Medical supplies and supplies associated with covered devices or equipment that are included in the rental fee or purchase price of the device or equipment are covered.

- Education Expenses:
  - The Plan does not provide benefits for services required to determine appropriate educational placement for services or for other educational testing, nor does it provide benefits for special education and related services, assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations, including but not limited to therapy services, cognitive retraining and rehabilitation, services for remedial education, evaluation and treatment of learning disabilities and disorders, interpreter services and lessons in sign language.
  - Physicals required solely for participation in school or school athletics.
- Efficacy:
  - Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as "Procedures") not proved to be safe and/or efficacious, or, because of a Participant's condition, an efficacious procedure that will have no effect on the outcome of the Participant's illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized United States authorities or United States governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Procedures that are ineffective or are in the stage of being tested or researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a particular illness, injury or disease which have received approval from the Federal Food and Drug Administration and/or the Agency for Healthcare Research & Quality may be Covered. CDPHN reserves the right to determine Coverage on a case-by-case basis.
- Eligibility:
  - Charges for treatment received before coverage under this option began or after it is terminated.
- Experimental/Investigational:
  - Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Administrative Agent's judgment, Experimental and/or Investigational for the diagnosis for which you are being treated.
  - Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an Illness or Injury, as determined by the Administrative Agent.
- Felony:
  - Any Health Services for a Participant resulting from the Participant's commission of a felony.
- Foot Care:
  - Foot care only to improve comfort or appearance.
  - Routine care of corns, bunions (except capsular or related surgery) or calluses, toe nails (except surgical removal or care provided as treatment of a diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints related to the feet. (Coverage is available for Medically Necessary foot care required as part of treatment of diabetes and for patients with impaired circulation in the lower extremities).
  - Shoe inserts.
  - Orthotics (except that they will be covered if prescribed by a physician for treatment of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy or chronic arterial or venous insufficiency).
- Government Agency/Laws/Plans:
  - Subject to any applicable secondary payor rules, treatment where payment is made by any local, state, or federal government or government health plan (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
  - Subject to any applicable secondary payor rules, services paid under Medicare or which would have been paid if you had applied for Medicare and claimed Medicare benefits. Subject to any applicable secondary payor rules, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not you have enrolled Medicare Part B.

- Services covered or recoverable under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
- The Plan will not pay for treatment provided in a governmental Hospital, or other institution which is owned, operated or maintained by the Veterans Administration, the federal government, a state government, or any local government, unless the Hospital is a Participating Provider. However, CDPHN will pay for care Covered under the Plan in a governmental Hospital, if because of serious injury or sudden illness, a Participant is taken to such a Hospital for Emergency care because it is close to the place where he/she was injured or became ill. In this type of Emergency situation, CDPHN will continue to make payments only for as long as Emergency care, in CDPHN's sole judgement, is necessary and until it is possible for the Participant to be transferred to a Participating Provider Hospital.

- Court-ordered services, or those required by court order as a condition of parole or probation (unless Medically Necessary and approved by the Plan).
  - Such services include, but are not limited to, custodial evaluations, special medical reports not directly related to treatment and reports prepared in connection with legal actions.
- Hearing aids
- Immunizations:
  - Immunizations if the sole purpose is to meet requirements for school, work or personal travel.
- Legal Restrictions:
  - Benefits otherwise provided in the Plan which CDPHN or the Plan is unable to provide because of any law or regulation of the federal, state or local government, or any action taken by any agency of the federal, state or local government in reliance on said law or regulation.
- Medically Necessary:
  - Care, supplies or equipment that are not Medically Necessary, as determined by the Administrative Agent, for the treatment of an Injury or Illness. This includes, but is not limited to, care which does not meet the Administrative Agent's medical policy, clinical coverage guidelines or benefit policy guidelines.
  - Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary to treat a specific Illness.
  - Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
  - Services for Hospital confinement primarily for diagnostic studies.
  - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect.
- Mental Health Care:
  - The Plan will not provide benefits for non-medically necessary Mental Health Care or Chemical Dependency care in facilities licensed to provide residential treatment (longer term supervised structured environment, room and board and counseling services).
  - The Plan will not provide Benefits for Mental Health Conditions that include motor disorders, communication disorders, or mental retardation solely for the purposes of education.
  - The Plan will not provide benefits for marriage counseling, pastoral or religious counseling, compulsive gambling, assertiveness training, music or art therapy or recreational therapy, smoking cessation therapy, caffeine cessation therapy, hypnosis and hypnotherapy, rolfing, psychodrama, psychoanalysis, self-treatment or self-help training.
- Miscellaneous:
  - Donor Search/Compatibility Fee (except as otherwise indicated)
  - Sperm preservation in advance of hormone treatment or gender surgery.
  - Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth.
  - Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided under "Covered Services."
  - Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research, travel, school or camp.
  - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

- Christian Science Practitioner.
- Services provided in a halfway house.
- Treatment or services provided by a non-licensed provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of you for which, in the absence of any health benefits coverage, no charge would be made; services provided to you by a local, state, or federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if you are not required to pay for them or they are provided to you for free.
- Benefits or services prescribed by a Physician but not expressly Covered by the Plan.

- Nutritional Supplements:
  - Dietary supplements or replacements. Not included in the exclusion is total parenteral nutrition.
- Over-the-Counter Items:
  - Over-the-Counter drugs, devices, products or supplies, without a prescription and except where required to be covered as Preventive Care under the ACA.
  - Drugs, devices, products or supplies with over-the-counter equivalents or which are therapeutically comparable to an over-the-counter drug, device, product or supply.
- Outside Service Area: Non-Emergency Health Services rendered outside the Service Area where the Participant should have reasonably foreseen the need for such services prior to leaving the Service Area, unless CDPHN approves such services in writing, in advance.
- Prior Authorization Not Obtained:
  - Services for which Prior Authorization was required but not obtained, except where a precertification penalty applies in lieu of a Benefit denial.
- Special Charges/Services:
  - Services or supplies provided by a member of your family (spouse, brother, sister, parent or child) or household.
  - Charges or any portion of a charge in excess of the Allowed Charge.
  - Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
  - Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
  - Charges for any of the following administrative fees: failure to keep a scheduled visit; completion of Claim Forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results, specific medical reports including those not directly related to your treatment, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
  - Any expense as a result of a Participant's failure to vacate his/her Hospital bed beyond the discharge time or date established by the Hospital, Participating Physician and CDPHN.
  - Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
  - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience while an inpatient in a Hospital or other health care facility, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone or other telecommunication charges, radio and TV rentals, homemaker services, travel expenses and take-home supplies.
- Subrogation/Reimbursement:
  - Any services for which a third party may be responsible as described in Coordination of Benefits, Subrogation and Reimbursement, except that the Plan has discretion to pay Benefits for certain of such services where the Participant signs an acceptable reimbursement agreement.
- Surgery:
  - Reversal of vasectomy or tubal ligation.
  - Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

- Therapies:
  - Services for outpatient therapy or rehabilitation other than those specifically noted.
  - Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, inhome wrap around treatment, wilderness therapy and boot camp therapy.
- TMJ
  - Coverage for temporomandibular joint disease (TMJ) is excluded when it is dental in nature.
- Travel and Transportation:
  - Travel and transportation expenses even though prescribed by a Physician, except as explicitly provided elsewhere in this SPD, such as those for Organ Transplant Benefits.
- Vision Care:
  - Routine vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations, fittings and services.
  - Vision Surgeries—Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- Visit Limits Exceeded:
  - Long-term Physical/Speech/Occupational Therapy, Chiropractic, Acupuncture, long-term rehabilitation or any other service in excess of the Plan's visit limits.
- Weight Reduction Programs:
  - Services for intensive weight reduction programs, services and supplies, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

This list is intended to provide you with a brief description of the key types of charges not covered by the Plan. Claims may also be denied for failure to comply with other provisions of the Plan, or if the Administrative Agent determines that a service is not Medically Necessary in accordance with its medical management protocols. To be certain of the benefits available to you, contact Member Services at the number shown on your I.D. card.

SECTION TWENTY-SIX—Coordination of Benefits, Subrogation and Reimbursement

Coordination of Benefits

When You Have Other Health Benefits.

It is not unusual to find yourself covered by two group health insurance contracts, plans, or policies providing similar benefits. When that is the case and you receive an item or service that would be covered by both plans or policies, the Plan will coordinate benefit payments with any payment made under the other policy or plan. One plan will pay its full benefit as a primary benefit. The other plan will pay the difference as secondary benefits if necessary to bring the reimbursement amount up to that plan's benefit level (if it is higher than the benefits paid by the primary plan). This prevents duplicate payments and overpayment.

This Coordination of Benefits (COB) provision applies to Plan Benefits when a Participant has health insurance coverage under more than one Group Benefit Plan as defined below. If this COB provision applies, the *Order of Benefit Determination* rules should be looked at to determine which plan pays first.

If a covered Participant is eligible for services or benefits under two or more Group Benefit Plans, the coverage under those plans will be coordinated so that up to, but no more than, the total Allowable Expenses during the Claim determination period will be paid for, or provided by, all the plans, less any Copayments, Coinsurance and Deductibles. The Plan, as a secondary payer, may reduce its benefits so that the total benefits paid or provided by the plans during a Claim determination period are not more than the total Allowable Expenses. The benefits of this Plan:

- Will not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another Group Benefit Plan; but
- May be reduced when, under the order of benefits determination rules, another Group Benefit Plan determines its benefits first.

Additional Definitions

The following additional definitions will apply exclusively to this section:

Group Benefit Plan: any of the following which provide benefits, indemnification or services for, or because of, medical or dental care or treatment covered by this Plan. Each of the following is considered to be a Group Benefit Plan that coordinates benefits with the Plan:

- Group insurance or group-type coverage, whether insured or uninsured. This includes:
  - Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered to be a health insurance policy.
  - Any self-insured or non-insured plan, or any other plan arranged through any employer, company trustee, union, employer organization, or employee benefit organization.
  - Any Blue Cross, Blue Shield, or other service type group plans or group remittance subscriber contracts.
- Any coverage under governmental programs, or any coverage required or provided by a statute. However, Medicaid (Grants to States for Medical Assistance Programs, Title XIX of the United States Social Security Act, as amended from time to time) and any plan whose benefits are, by law, in excess of those provided by any private insurance plan or other non-governmental plan shall not be considered a Group Benefit Plan.
- Medical benefits coverage in-group and individual mandatory automobile "no-fault" or traditional "fault" type contracts.

Each contract or other arrangement for coverage under any bulleted item above is a separate Group Benefit Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Group Benefit Plan.

Primary Plan/Secondary Plan: The *Order of Benefit Determination* rules determine whether this Plan is a Primary Plan or a Secondary Plan as to another Group Benefit Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Group Benefit Plan and without considering the other Group Benefit Plan's benefits. When this Plan is a Secondary Plan, its benefits are determined after those of the other Group Benefit Plan and may be reduced because of the other Group Benefit Plan's benefits. When there are more than two Group Benefit Plans covering the individual, this Plan may be a Primary Plan as to one or more other Group Benefit Plans, and may be a secondary plan as to a different Group Benefit Plan or Group Benefit Plans.

Allowable Expense: a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more Group Benefit Plans covering the individual for whom the Claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a primary plan because a covered individual does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provision are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim Determination Period: the Plan Year. However, it does not include any part of a Plan Year during which an individual has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination.

When there is a basis for a Claim under this Plan and another plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan unless:

- The other Plan has rules coordinating its benefits with those of this Plan, and both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan; or
- The other Plan is a governmental Plan or coverage required or provided by law, and this Plan is required by law or regulation to be the Primary Plan. A basis for a claim under a governmental Plan can exist when a covered person is covered or eligible for coverage under the Plan, whether or not the covered person applies for or receives benefits thereunder. The conditions shown are current examples (subject to change) of some of the areas in which this Plan is required to be the Primary Plan.
  - The covered person is covered under the Civilian Health and Medical Program of the Uniformed Services (Tri-Care).
  - The covered person is covered under Medicaid.
  - The covered person is actively at work and is age 65 or older, and is enrolled as a Subscriber or as a Dependent of a Subscriber (of any age) in the group coverage of a subscribing group with 20 or more employees.

The benefits available to covered Participant under any other Plan will be coordinated pursuant to the provisions of this section to avoid duplicate payment to covered persons for the same or similar benefits or services.

This Plan determines its order of benefits using the first of the following rules which applies:

- *Non-Dependent/Dependent:* The benefits of the Plan which covers the person as an employee, insured, participant or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the individual as a dependent.
- *Dependent Child/Parents not Separated or Divorced:* Except as stated in Rule C below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
    - The benefit of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
    - If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described in the first bulleted item immediately 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 of the other Plan will determine the order of benefits.
- *Dependent Child/Parents Separated or Divorced:* If two or more plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the Plan of the parent with primary custody of the child;
    - Then, the Plan of the spouse of the parent with the primary custody of the child; and
    - Finally, the Plan of the parent not having primary custody of the child.
    - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense 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. The Plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before the entity has that actual knowledge.
- *Joint Custody:* If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in *Dependent Child/Parents not Separated or Divorced*.
- *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). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, then this rule is ignored.
- *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, insured, member, covered person, participant, beneficiary or subscriber longer are determined before those of the plan which covered that individual for the shorter term.

Effect on the Benefits of This Plan When This Section Applies

This section applies when, in accordance with the above section, *Order of Benefit Determination Rules*, this Plan is a Secondary Plan to one or more Group Benefit Plans. In that event, the benefits of this Plan may be reduced under this section.

When the Plan is the Secondary Plan, the benefits of the Plan will be reduced so that the total benefits payable under the other policy or plan and the Plan do not exceed the charges for the service, but in no event will the Plan pay more than it would have paid if it were the Primary Plan. The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expenses under the other Group Benefit Plans, in the absence of provision with a purpose like that of this COB provision, whether or not a Claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Group Benefit Plans do not total more than those Allowable Expenses.

Only the amount of benefit actually paid by this Plan may be charged against any applicable benefit limit under this Plan.

Note: When the Plan is the Secondary Plan, prior authorization is not required for Inpatient Hospital Services.

Coordination with Specific Group Benefit Plan Types

Motor Vehicle No-Fault Insurance

If a covered person owns and operates a motor vehicle on the public highways, the covered person is required to have no-fault insurance, which covers certain medical and rehabilitation expenses incurred if a covered person or others are injured in an automobile accident.

The Plan is authorized by law to coordinate its coverage with a covered person's no-fault insurance. This means that if a covered person is injured in an automobile accident, the automobile no-fault insurance will pay first, and the Plan will provide coverage only if the amount of no-fault coverage is insufficient to pay for all of the medical expenses.

Coverage under the Plan may include the amount of the deductible under the no-fault coverage.

If a covered person is injured while riding in or operating a vehicle owned by the covered person, and the vehicle is not covered by no-fault insurance as required by law, benefits under the Plan will not be available to the covered person, up to the minimum amount of no-fault insurance coverage required by law.

This denial of benefits will not apply to any covered person injured in an automobile accident if the injured covered person is a non-owner operator, passenger, or pedestrian and the vehicle is not covered by no-fault insurance.

If the no-fault insurance policy provides coverage in excess of the minimum required by law, the Plan will coordinate benefits with the amount of the coverage provided. If there is an automobile policy in effect, and the covered person waives or fails to assert his/her rights to the no-fault benefits, the Plan will not pay the benefits that would have been available under the no-fault policy.

The Plan reserves the right to require proof that the automobile policy has paid all benefits required by law before the Plan pays any benefits.

After benefits under the no-fault policy have been exhausted, coverage under the terms of the Plan will be available only if the insured obtains all medical care for covered benefits in compliance with the Plan.

Workers' Compensation

The Plan will not provide benefit services or supplies required as a result of a work-related illness or injury. This applies to illness or injury resulting from occupational accidents or sickness covered under any of the following:

- Occupational disease laws;
- Employer's liability;
- Federal, State or municipal law;
- The Workers' Compensation Act.

To recover benefits for a work-related illness or injury, the covered person must pursue his/her rights under the Workers' Compensation Act or any of the above provisions that may apply to the illness or injury. This includes filing an appeal with the Industrial Commission, if necessary.

When a legitimate dispute exists as to whether an injury or illness is work-related, the Plan will provide benefits during the appeal process if the covered person signs an agreement to reimburse the Plan for 100% of the benefits provided.

The Plan will not provide benefit services for a work-related illness or injury even under the following circumstances:

- The covered person fails to file a claim within the filing period allowed by law.
- The covered person obtains care that is not authorized by Workers' Compensation.
- The covered person fails to comply with any other provisions of the law.
- The covered person has a choice of providers, which includes a network provider, elects to use a non-network provider and the claim is subsequently denied by Workers' Compensation.
- Benefits will not be denied to an employee whose employer has not complied with the laws and regulations governing Workers' Compensation Insurance, provided that such employee has sought and received services under the provisions of the Plan.

Medicare.

Coordinating payment of Benefits When Medicare is Primary.

The Plan coordinates health benefits with Medicare in accordance with the Medicare Secondary Payer Rules. When Medicare is primary, the Plan pays benefits only after Medicare has paid its benefits. The Plan generally pays health benefits after Medicare for retired employees and/or their dependents eligible for Medicare, for COBRA beneficiaries eligible for Medicare, and for disabled employees for whom the Plan is no longer primary (and their Spouses and Dependents). Retirees and their spouses age 65 and older should enroll for both Parts A and B of Medicare. Otherwise, neither the Plan nor Medicare may not cover the expenses.

If a Participant is also covered under another group plan and federal rules require that other group plan to pay primary to Medicare, the Plan is secondary to both that plan and Medicare. This is true even if the Plan is determined to be primary to that other group plan by the rules shown in Coordination of Benefits. Federal rules determine the order of payment between Medicare and the other plan.

Medicare Pays First and the Physician Accepts Assignment:

If the Provider has agreed to limit charges for services and supplies to the amount approved by Medicare, then the Provider is said to have "accepted assignment." When a Provider accepts assignment, the Provider agrees to bill no more than Medicare's approved amount. Any difference between the physician's charges and Medicare's approved amount is not the responsibility of the covered person.

When Medicare is primary and the Provider has "accepted assignment" the Plan will calculate the amount of the covered expense using the Medicare approved amount.

In the following example, the Physician accepts assignment so both the Plan and Medicare will base their calculations on the Medicare approved amount of $70.00.

Example (a)—In-Network payment for an office visit.

Plan Benefit: $20 copay and then 100% coverage.
Physician: charges $100
Medicare: allows $70 and pays 80% of the allowed amount, or $56.00.

The Plan pays $0. Although the Plan considers $90 to be the reasonable charge, the Plan calculates 100% of the Medicare Allowed Charge ($70) and determines $70 is the Plan benefit. In this instance the $20 copay + Medicare ($56) + $0 = $71*. You pay: $20 co-pay when the service is provided. You are not responsible for the difference between the physician charges and the Medicare Allowed Amount.

Cost	Medicare Allows**	Medicare Pays	Plan Pays	You Pay
$100	$70	$56	$0	$20 Copay

* Provider refunds $6.00 to reimburse employee/patient.
** Physician required to accept

Medicare Pays First and Physician Does Not Accept Assignment:

If the Provider has not agreed to limit charges for services and supplies to the amount approved by Medicare, then the Provider does not "accept assignment." If the Provider has not "accepted assignment," the covered person is responsible for physician-billed charges not covered by Medicare and the Plan. However, the physician cannot bill more than 15% above Medicare allowed amount.

When Medicare is primary and the Provider has not "accepted assignment," the Plan will calculate the amount of the covered expense based on the lesser of the following:

- The reasonable charges, or
- The amount that the Provider charged.
  - Next, The Plan determines the amount payable without regard to Medicare benefits.
  - The Plan then subtracts the amount payable under Medicare from amount payable under the Plan benefits. *The Plan pays only the difference between Medicare benefits and the Plan benefits for the same expenses.*

In the following example, the Physician does NOT accept assignment so, the Plan will base its calculations on the reasonable charges ($90), as they are less than the amount the Provider charged ($100). Medicare will base its calculations on the Medicare allowed amount ($70).

Example (b)—In-Network payment for an office visit.

In this situation payment would be the same as noted in the previous In-Network example (a). As most In Network Providers participating in the Plan "accept assignment," you will not likely experience an In-Network office visit charge from a physician that does not "accept assignment."

Subrogation and Reimbursement.

In situations where another party is legally responsible for an Illness or Injury that you have sustained, and where the Plan has provided benefits, you must assign and subrogate to the Plan all your legal rights against that party to the extent of the reasonable value of the benefits provided to you. Also, you must pay the Plan any amounts recovered by suit, settlement or otherwise from that party or his insurer to the extent of the reasonable value of the benefits provided to you. You must provide the Plan any relevant information requested and must do whatever else is necessary to help the Plan recover the value of those benefits provided to you.

The Plan will not cover any services or supplies for which a third party is or may be liable or has agreed to make payment. In such cases, all of the following will apply:

- The covered Participant shall promptly notify the Plan of any claim against or recovery from the third parties.
- The covered Participant shall cooperate in every necessary way to help the Plan enforce its right to pursue and collect from the third party.

- The covered Participant shall hold recovery proceeds in trust for the Plan and the Plan shall have a lien on any proceeds of a recovery.
- The Plan shall be subrogated and will succeed to any covered person's right of recovery from a third party for the amount of actual expenses paid by the Plan, as well as future medical expenses not yet incurred, which are related directly to the injury or illness and are the responsibility of a third party.

The covered Participant will reimburse the Plan as explained below:

- When the covered Participant has received payment from the third party, as a result of judgment, settlement, or otherwise, the covered Participant will first reimburse the Plan for the amount of actual expenses paid. An agreement pertaining to a fair present value payment or trust account to cover future medical expenses will be established by the Plan and the covered Participant in the event of a lump sum award or settlement of a claim for future medical expenses. In the absence of such an agreement, the Plan will exclude coverage for future medical expenses related to the injury or illness up to the amount of the award.
- The right of reimbursement of the Plan comes first even if a covered Participant is not paid for all of his claim for damages against the other person or organization or if the payment he receives is for, or is described as for, his damages (such as for personal injuries) for other health care expenses or if the covered Participant recovering money is a minor.
- The Plan will be reimbursed subject to reduction equal to the Plan's pro rata share of the attorneys' fees and costs incurred by the covered Participant in obtaining the recovery. In no event will the Plan pay more than 33 percent of the Plan's recovery in attorney's fees.
- Should a covered Participant refuse or fail, for any reason, to pursue his rights, then the Plan will have the right to initiate an action as subrogee in the covered Participant's name or in the Plan's name, at the Plan's election, to recover eligible charges provided under the Plan, and the covered Participant will cooperate fully in the pursuit of any such action.
- The covered Participant will, on request, execute and deliver whatever documents or whatever else the Plan determines is necessary to carry out the provisions of this section.

The provisions of this section are binding on all covered Participants by virtue of section titled *Covered Person's Agreement*. However, the Plan may condition the payment of benefits on the covered Participant's (or his/her personal representative's) express written acceptance of the provisions of this section.

Right to Receive and Release Necessary Information.

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. The Plan need not tell, or get the consent of, or provide notice to, any individual to do this. CDPHN has the right to release or obtain information it believes is necessary to administer this coordination of benefits provision. CDPHN will not notify you or obtain your consent before releasing or obtaining information. Neither the Plan nor CDPHN will be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to CDPHN any relevant information it requests. The Plan reserves the right to deny benefit payments if you refuse to comply with CDPHN's request for information.

Payments to Others.

A payment made under another Group Benefit Plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. The Plan may repay to any third party—a person, an insurance company, or other organization—the amount that party paid for your covered services that CDPHN determines should have been paid under the provisions of the Plan. That amount will then be treated as though it were a benefit paid under this Plan. These payments are the same as benefits paid to you and they satisfy the Plan's obligation to you, and the Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

The Plan's Right to Recover Overpayment.

In some cases the Plan may have made payment even though you had coverage under another policy or plan, or even though a third party was responsible. Under these circumstances, it will be necessary for you to refund to the Plan the amount by which the Plan should have reduced its payment. The Plan also has the right to recover the overpayment from the other health benefits program if you have not already received payment from that other program.

If the amount of the payments made by this Plan is more than it should have paid under the COB or Subrogation and Reimbursement provision, it may recover the excess from one or more of:

- The individuals it has paid;
- The Participants for whom it has paid;
- Insurance companies or third party administrators; or
- Any other person or organization who benefited from the overpayment.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

You must sign any document that CDPHN regards as necessary to help it recover any overpayment.

SECTION TWENTY-SEVEN—Continuation Coverage Rights Under COBRA

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become qualified beneficiaries under COBRA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health plan coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Child could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your Spouse dies;
- your Spouse's hours of employment are reduced;
- your Spouse's employment ends for any reason other than his or her gross misconduct;
- your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- the parent-Employee dies;
- the parent-Employee's hours of employment are reduced;
- the parent-Employee's employment ends for any reason other than his or her gross misconduct;
- the parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse and/or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the Plan Administrator with a copy of the Social Security Administration's notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan's COBRA Administrator in accordance with the procedures above. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered Employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination. If you do not notify the Plan Administrator, the plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after the first day of the month beginning 30 days after the Social Security Administration determines that the disabled qualified beneficiary is no longer disabled.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and/or Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and/or any Dependent Child receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse and/or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period described on the election form.

If COBRA continuation coverage is elected, the qualified beneficiary must pay the initial premium (including all premiums due but not paid) within 45 days after the election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. The cost of COBRA coverage is 102 percent of the full cost of plan coverage (without any employer subsidy).

If you elect COBRA continuation and then fail to pay the premiums due within the initial 45-day grace period, or fail to pay any subsequent premium within 30 days after the date it is due, coverage will be terminated retroactively to the last day for which timely payment was made.

What is the Election Period and How Long Must it Last?

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event, and ends 60 days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date notice is provided to the qualified beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a qualified beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

- the last day of the applicable maximum coverage period;
- the first day for which timely payment is not made to the Plan with respect to the qualified beneficiary;
- the date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee;
- the date, after the date of the election, that the qualified beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary;
- the date, after the date of the election, which the qualified beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier); or
- in the case of a qualified beneficiary entitled to a disability extension, the later of:
    - 29 months after the date of the qualifying event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    - The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a qualified beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent Claim.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled qualified beneficiary due to a disability extension. The Plan will terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

What happens if I give notice of an event but I do not qualify for COBRA?

If the Plan Administrator receives notice of an event that it determines is not a qualifying event, or receives notice with respect to an individual that the Plan Administrator determines is not a qualified beneficiary, then the Plan Administrator will provide written notice of unavailability of COBRA continuation coverage to the affected individual within the time periods required for COBRA Election Notices. The notice will be written in an understandable manner and will explain why COBRA coverage is not available.

Do I have to keep family coverage if that is the coverage level I had when covered due to active employment?

No. You may elect the same level of coverage or any lower level of coverage (e.g., you may elect Employee only, Employee and Spouse, Employee and Child(ren), or Family coverage). Unless otherwise elected, all qualified beneficiaries who were covered under the Plan will be covered together. However, each qualified beneficiary may alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate deductible, out-of-pocket maximum and a separate premium for coverage.

What happens if I waive COBRA and later change my mind?

Qualified beneficiaries who reject COBRA continuation coverage before the Election Form due date may revoke their waiver by furnishing a completed COBRA Election Form before the due date. However, qualified beneficiaries who change their mind and revoke their waiver after first rejecting COBRA continuation coverage will begin COBRA continuation coverage on the date the qualified beneficiary furnishes the completed COBRA Election Form, and will not receive coverage retroactive to the date of the qualifying event.

What happens if Plan Coverage Changes During the Continuation Period?

If coverage under the plan is changed for active Employees, the same changes will apply to individuals on COBRA continuation coverage.

Are there circumstances when COBRA coverage might terminate early?

Yes. Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or
- the Employer ceases to provide any group health plan for its Employees.
- Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or covered dependent not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. The Plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after the event that allowed early termination of COBRA coverage if the qualified beneficiary does not notify the Plan Administrator immediately of such coverage.

In the event of early termination, the Plan Administrator will provide the qualified beneficiaries with written notice as required by COBRA. The notice will be furnished as soon as practicable following the Plan Administrator's determination that continuation coverage will terminate, will be written in an understandable manner, and will contain the following information:

- the reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event;
- the date of termination of continuation coverage; and
- any rights the qualified beneficiary may have under the Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Federal Marketplace or the NY Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

What is the Health Insurance Marketplace?

The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost cage fromMedi or the Children's Health Insurancrogram (CHIP). You can access the Federal Marketplace four state at www.HealthCare.gov.

Coverage through the Federal Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Federal Marketplace.

Certain states have their own marketplaces, while other states use the Federal Marketplace. If you live in New York State, you may purchase insurance through the NY Marketplace. New York residents should contact theMarketplace at https://nyseofhealth.ny.gov/ or 1-855-355-5777 for more information. If you live in another state, you can access the Marketplace for your state through the Federal Mtplace web site, www.HealthCare.gov.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in Marketplace coverage. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrent periods, visitwealthCare.gov (or httpsnystateofhealth.ny.gov/ for the New York Marketplace).

If I sign up for COBRA continuation coverage, can I switch to covÒerage in a Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though—if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances after your 60-day COBRA enrollment period expires.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** The Employer health care plans can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas—so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments. Also, if you have already satisfied your deductible through the Employer health care plans for the plan year, you may want to wait to enroll in Marketplace coverage until the next open enrollment period or else you may have to pay a new deductible.

SECTION TWENTY-EIGHT—General Information and ERISA Guidelines

Assistance with Your Questions.

If you have any questions about the Plan, you should contact the Plan Administrator at the address in the *Plan Information* section. If you have any questions about benefits or claims, you should contact CDPHN member services.

Maternity and Newborn Infant Coverage Statement

Under Federal law, none of the group health plans offering maternity or newborn infant coverage may restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

Women's Health and Cancer Rights Act

All group health plans and their insurance companies or health maintenance organizations that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans, insurance companies, and HMOs may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the plan or coverage. See the certificate of coverage and the Summary of Benefits and Coverage (SBC) for the Medical Insurance Program for information on cost-sharing requirements.

Health Insurance Portability and Accountability Act (HIPAA)

In addition to establishing standards for electronic health care transactions and unique national identifiers, Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides the legal standards for the privacy and security of protected health information (PHI). PHI includes information that we have created or received about your past, present or future health or medical condition that could be used to identify you. All Employee protected health information (PHI) is maintained in a manner consistent with the privacy standards established by HIPAA. Further, the Plan Sponsor will provide you with a Notice of Privacy Practices, which describes how the Plan uses information about you and when we can share that information with others in addition to how you can get access to this information.

The following persons have been designated by the Plan as authorized to use or disclose Protected Health Information for purposes of Plan Administration and have received appropriate training regarding the Plan's health information privacy policies and procedures and the applicable requirements of the Privacy Regulations:

- Vice President Human Resources, Benefits Office Staff

All PHI, manual and electronic, shall be maintained in a manner consistent with privacy standards established by HIPAA.

Clerical Error and Plan's Right to Recover Erroneous Payments

Any clerical error by the Plan Administrator and/or Administrative Agent in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force, or continue coverage validly terminated.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if the overpayment is not repaid when requested, the amount of overpayment will be deducted from future benefits payable.

To the extent permitted by law, if, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to you or your dependents, you will be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, Administrative Agent, the Plan Administrator or the Employer (or designee) may recover that incorrect payment, whether or not it was made due to Administrative Agent's or the Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Administrative Agent or the Plan Administrator (or its designee), the refund or repayment may be made in one or a combination of the following methods:

- in the form of a single lump-sum payment;
- as a reduction of the amount of future benefits otherwise payable under the Plan;
- as automatic deductions from pay; or

- any other method as may be required or permitted in the sole discretion of the Administrative Agent or Plan Administrator.

The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Amendment and Termination

The Employer/Plan Sponsor and the Plan Administrator (or such other person or committee the Employer so designates) expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason, including, but not limited to, the right to change eligibility, any benefit provisions and required premium contributions, Deductibles and Copayments. Notwithstanding any other provision in the Plan or this SPD to the contrary, no Plan Participant or other beneficiary shall have any right to benefits under the Plan or SPD which in any way interferes with the Employer's right to terminate the Plan or amend the Plan. There are no contractual rights to benefits under the Plan. **YOUR EMPLOYER MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS DO NOT VEST.** In particular, termination of employment or retirement does not in any manner confer upon any Plan Participant or other beneficiary any irrevocable right to continued benefits under the Plan.

If the Plan is terminated, the rights of the Plan Participant are limited to expenses incurred before termination.

The right reserved to the Employer/Plan Sponsor and the Plan Administrator to amend and terminate the Plan or any component Program, as exercised by the Employer/Plan Sponsor or Plan Administrator or its duly authorized delegate, shall be a power reserved to the Employer as settlor or sponsoring employer, as applicable; no action taken pursuant to that right shall be subject to Appeal by any person claiming a right under the Plan or any component Program except as may otherwise be provided by applicable law.

General Agreement

Covered Person's Agreement

The covered Participant must pay the premiums, Deductibles, Coinsurance and/or Copayments applicable to the Plan under which he/she is enrolled. Copayments should be paid to the provider at the time of service.

By choosing the coverage specified in the Plan, paying any required contribution, or accepting benefits in accordance with the Plan, all covered Participants, for themselves and their legal representatives, expressly agree to all terms, conditions and provisions of the Plan, including but not limited to those involving *Subrogation and Reimbursement*.

The Plan's Agreement

All rules and decisions of the Plan Administrator and the named fiduciary shall be uniformly and consistently applied to all persons in similar situations. In compliance with federal and state law, the Plan shall not discriminate on the basis of age, sex, color, race, disability, marital status, sexual orientation, religious affiliation, or public assistance status in the administration of this Plan.

Legal Relationship of Parties

The Plan Administrator shall have the final discretion to determine eligibility and Employee financial participation requirements. The Administrative Agent will administer all benefit Claims under the Plan and shall have the final discretion to determine benefits payable. The Administrative Agent will provide the Plan Administrator with information necessary to assist the Plan Administrator in meeting any applicable ERISA reporting requirements.

The Administrative Agent is an independent contractor retained by the Plan Administrator to provide an insurance contract and administration under the Medical Insurance Program, and a pharmacy network, Claims processing and services necessary for the operation of the Pharmacy Benefits Program. The Plan Administrator and the Administrative Agent are not joint venturers and neither party is the partner or agent for the other party, except that the Administrative Agent is an agent of the Plan when performing its obligations under the Plan Documents. The Plan Administrator is not an agent of the Administrative Agent under any circumstances.

Neither party shall be obligated to make and shall not make, any payments to employees of the other party for services rendered by them as employees of the other party. Employees of one party shall not be considered as having employee status with the other party or as being entitled to the benefits of any employee of the other party.

The rights of any covered person under the Plan may not be voluntarily or involuntarily assigned or alienated, except for valid assignments to Physicians/Providers, nor are they subject to the lien of any third party.

Access to Records

Either the Plan Administrator or the Administrative Agent will keep records about covered persons with details about their coverage. Upon request, the Plan Administrator will submit to the Administrative Agent or give the Claims Administrator reasonable access to, information and records about covered persons that may be required to administer Claims for the Plan.

Wrong Information/Erroneous Information

The Plan is not liable for fulfilling any obligation based on information it has not yet received in a form satisfactory to the Administrative Agent. Erroneous information can be corrected, unless the Plan has acted on the erroneous information to its disadvantage.

Misuse of ID Card

ID cards issued to covered persons are solely for purposes of identification. Possession of a card does not ensure eligibility and confers no rights to services or other benefits.

The holder of an ID card must be a covered person for whom any required contributions under the Plan have been paid.

If a covered person permits the use of his/her ID card by any other person, then card will be reclaimed by the Plan and all rights of the covered person and his/her Spouse and Dependent Children under the Plan will be terminated. Notice of termination will be sent 30 days before benefits cease, but will be effective retroactive to the date of the fraudulent use of the ID card.

Payment for services or other benefits received improperly through the use of an ID card is the financial obligation of the individual or individuals who used the ID card improperly.

Statement of ERISA Rights

Participants in the plans covered by this summary have certain legal rights under Federal law. The Department of Labor requires that you be informed of these rights in the following form:

As a participant in the plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) (should it become necessary for the plan to file a Form 5500), filed by the plan with the U.S. Department of Labor.
- Obtain upon written request to the plan administrator copies of documents governing the administration of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (should it become necessary for the plan to file a Form 5500) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your Claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal

court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION TWENTY-NINE—Claims and Appeals

Claims and Appeals Procedures.

Any Participant, or an authorized representative acting on behalf of a Participant, may assert a Claim for eligibility or benefits. Throughout this Plan and the Claims and Appeals procedures in Appendix A, any of these individuals are referred to generically as "the Claimant."

Claims relating solely to eligibility to participate in the Plan are decided in accordance with the Eligibility Claims procedures in Appendix A.

All Claims for Plan Benefits must be submitted in accordance with the Benefits Claims procedures in Appendix A. In the case of In-Network Benefits, Participating Providers generally complete the initial Claim submission on your behalf. See *How the Plan Works* for more information.

In some cases, Benefits Claims may also be subject to third party external review, as described in Appendix A.

Statute of Limitations and Exhaustion of Administrative Remedies

All Claims for benefits must be submitted by the Claims filing deadline specified under the rules for that benefit Program. If the benefit Program does not specify a filing deadline, then Claims must be submitted within one year from the date the services relating to the Claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the Participant or Beneficiary, the Claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late Claims will never be accepted if they are filed more than two years from the date the services relating to the Claim were performed or the event that gave rise to the benefit occurred.

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Claims Reviewer, the Plan Sponsor, or any other person, with respect to a Claim for disability, medical, or other Claims for benefits without first exhausting the Claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on Appeal of a denied Claim may bring an action under Section 502 of ERISA in an appropriate court to review the Claims Reviewer's or Plan Administrator's decision on Appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on Appeal.

Notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan Claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA as applicable, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the third anniversary of the Claims Reviewer's decision on Appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, as applicable, without first exhausting the Claims procedures set forth above if the violation by the Plan was:

- *De minimis*;
- Not likely to cause, prejudice or harm to the Claimant;
- Attributable to good cause or matters beyond the Plan's control;
- In the context of an ongoing good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal Claims and Appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal Appeal of the Claim within a reasonable time after the external reviewer or court rejected the Claim for immediate review (but not to exceed ten days). Time periods for re-filing the Claim shall begin to run upon Claimant's receipt of such notice.

SECTION THIRTY—Plan Information

Plan No.	Plan Name	Plan Types
[507]	The Saratoga Hospital Group Benefit Plan	Welfare: Medical Insurance and Prescription Drug Benefits

Saratoga Hospital
211 Church St.
Saratoga Springs, NY 12866
(518) 583-8435

The Plan Year runs from January 1 to December 31 each year.

TAX ID 14-1338547

The Plan Administrator is the "named fiduciary" for the Plan within the meaning of Section 402(a) of ERISA.] Notwithstanding any other provision in the Plan and this SPD, and to the full extent permitted by ERISA and the Code, the Plan Administrator (and its designees and representatives) possesses full discretionary authority to control and manage the operation of the Plan, to construe and interpret the terms of the Plan, and to delegate and allocate responsibilities for the operation and administration of the Plan to others. The Plan Administrator's exercise of this discretionary authority shall be binding and shall be given deference on any judicial (or other) review, to the fullest extent permitted by law. Notwithstanding the foregoing, to the extent an insurer exercises sole discretionary authority or discretionary responsibility over the benefit Claims procedure, it shall be the only fiduciary for purposes of the Plan with authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates.

Agent for Service of Legal Process

The agent for Service of Process is the Employer, at the address given above. Process may also be served upon the Plan Administrator.

Medical Plan:

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, N206-1057
(518) 641-3100
http://www.cdphp.com/Members

Prescription Drug Program:

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3100 or 1-877-724-2579
http://www.cdphp.com/members/rx-corner

Caremark Inc.
P.O. Box 686005
San Anto TX 78268-6005
88-292-6330
www.caremark.com

Benefits are funded by Employer and Employee contributions which are held as part of the Employer's general assets. Claims are paid from the Employer's general assets. Plan benefits are self-insured by the Saratoga Hospital and administered through contract administration by CDPHN and Caremark.

APPENDIX A—CLAIM REVIEW AND APPEALS PROCEDURES

The following procedures apply if you (or an authorized representative acting on your behalf) are inquiring about your eligibility to participate in a benefit offered under the Plan. These rules do not apply if you are claiming the right to receive benefits rather than just inquiring about your eligibility. If you are filing a Claim for benefits, please refer to the information above and below regarding benefits Claims.

Any Claim for eligibility shall be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the Claimant of its decision within 90 days after it receives the Claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the Claim, it may obtain an additional 90 days to decide the Claim. Before obtaining this extension, the Plan Administrator will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If the Claim is denied in whole or in part, the Plan Administrator will provide the Claimant, within the time period described above, with a written or electronic notice which explains the reason or reasons for the decision, includes specific references to plan provisions upon which the decision is based, provides a description of any additional material or information which might be helpful to decide the Claim (including an explanation of why that information may be necessary), and describes the Appeals procedures and applicable filing deadlines.

If a Claimant disagrees with the decision reached by the Plan Administrator, the Claimant may submit a written Appeal requesting a review of the decision. The Claimant's written Appeal must be submitted within 60 days of receiving the initial adverse decision. The Claimant's written Appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant may submit written comments, documents, records and other information relating to the Claim even if such information was not submitted in connection with the initial Claim for benefits. Additionally, the Claimant, upon request and free of charge, may have reasonable access and copies of all Plan documents, records and other information relevant to the Claim.

The Plan Administrator will generally decide a Claimant's Appeal within 60 days. If special circumstances require an extension of time for reviewing the Claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the Appeal, which date will be no later than 60 days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the Claimant shall receive written or electronic notification of the decision within five (5) days. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that the Claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the Claim.

For the purposes of this section, the "Claims Reviewer" is the individual or entity assigned to review Claims or Appeals for a benefit. Where a benefit's materials specify that Claims be sent to an insurer or third party administrator, then the insurer or third party administrator (the "Administrative Agent") shall be the Claims Reviewer for purposes of the procedures that follow.

This procedure applies only to Claims submitted for Plan Benefits. In addition, it applies to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage under a Plan that is subject to PPACA. You will be provided with 30 days advance written notice of any rescission.

If you need assistance with your Claim, Appeal of a denied Claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All Claims and Appeals under the Plan will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the Claims an Appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

The Plan will continue to provide coverage pending the outcome of an Appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

A Claim for benefits is a request for Plan Benefits that is made in accordance with the Plan's Claims and Appeals procedures. Please note that the presentation of a prescription to be filled at a pharmacy, even if it is part of the Plan's network of participating pharmacies, does not constitute a Claim under the Plan. However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a Claim using these procedures.

This Claim procedure should also be used to seek reimbursement for non-Network Claims, or for any other situation where a service was already provided or a prescription was already filled but not paid by the Plan at the point of service. The Claims Form is available at www.CDPHP.com. Any Claim for reimbursement must be submitted, with proof of payment, within 90 days of the service date (prescription fill or attempt to fill at the pharmacy counter in the case of prescription drugs) to CDPHN at the following address:

Capital District Physicians' Healthcare Network, Inc.
P.O. Box 66602
Albany, NY 12206-6602

You should keep a copy of the claims form and receipt or proof of payment for your records. Please note the following:

- The date, the service, patient name and patient's CDPHN Identification number must be provided with the receipt.
- Failure to furnish such proof within 90 days of the date of service shall not invalidate nor reduce any claims, if the claim or bill is submitted as soon as reasonably possible. However, all claims must be submitted no later than December 31 of the year after the year in which the services were provided or the course of treatment was completed (except in the case of legal incapacity of the Participant).
- Participating Providers or Practitioners are responsible for submitting a claim for covered expenses to CDPHN for each service provided. In the event that a Participating Provider or Practitioner bills you for services covered under the Plan, contact CDPHN Member Services at the phone number on your ID card.

Internal Review of Benefits Claims

Definitions.

The following terms are defined for purposes of this section:

Post-Service Claim: means any Claim for a benefit which is not a Pre-Service Claim as defined below.

Pre-Service Claim: means any Claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care.

Urgent Care Claim: means a Claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the Claimant's life or health or the ability of the Claimant to regain maximum function, or
- In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

The determination of whether a Claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a Claim shall automatically be treated as an Urgent Care Claim if a physician with knowledge of the Claimant's medical condition determines that the Claim involves Urgent Care.

Claims Reviewer: means the person or entity responsible for the relevant Claims determination under the Plan.

Determination of Benefits.

The amount of time that the Claims Reviewer has to respond to a Claim for benefits will depend upon the type of Claim for benefits being made, as provided below.

- *Post-Service Claims.* The Claims Reviewer will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the Claim is received. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the Claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a Claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a benefit determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.
- *Pre-Service Claims.* The Claims Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the Claim. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Plan expects to decide the Claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit

information necessary to decide a Claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

In the event the Claimant fails to follow proper Plan procedures in submitting a Claim, the Claimant will be notified within five days after the Plan initially receives the Claim so that the Claimant can make proper adjustments.

- *Urgent Care Claims.* The Claims Reviewer will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Reviewer will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the Claim (the Plan will defer to the attending provider with respect to the decision as to whether a Claim is an Urgent Care Claim), unless the Claimant fails to submit information necessary to decide a Claim. In this situation, the Claimant will be informed within 24 hours after submitting the Claim the specific information necessary to complete the Claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Plan's receipt of the requested information or the end of the period the Claimant was given to supply the additional information. In the event the Claimant fails to follow proper Plan procedures in submitting a Claim, the Claimant will be notified within 24 hours after the Plan initially receives the Claim so that the Claimant can make proper adjustments.
- *Concurrent Care Decisions.* In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to Appeal the decision and obtain a determination on review before the benefit is reduced or terminated. If the Claimant requests to extend the course of treatment and the Claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the Claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such Claim at least 24 hours prior to the expiration of the initial treatment period.

Notification of Adverse Claim Determination

If the Claimant's Claim for benefits is denied, in whole or in part, the Claimant or the Claimant's authorized representative will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- sufficient information to identify the Claim involved, including the date of service, the health care provider, and if applicable, the Claim amount;
- references to the specific Plan provisions on which the benefit determination was based;
- a description of any additional material or information necessary for the Claimant to perfect a Claim and an explanation of why such information is necessary;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the Claim for benefits;
- a description of the Plan's internal Appeals procedures, any applicable the external review process, information regarding how to file an Appeal, and applicable time limits, including the right to bring a civil legal action: under ERISA if the Claim continues to be denied on review;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the Claim;

- the contact information for the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such Claims.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse Claim determination orally, but a written notification providing the information set forth above shall follow within three days.

Appeal of Adverse Claim Determination.

If a Claim for benefits is denied, the Claimant may Appeal the denied Claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with this Appeal any written comments, documents, records and any other information relating to the Claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the Claim free of charge. The Claimant is entitled to review the Plan's Claim file and to present evidence and testimony in support of his or her Claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the Appeal orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the Claim file and any new information submitted to support the Appeal, including all comments, documents, records, and other information will be conducted. The Claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor will the subordinate of the person making the initial determination. This review will not afford any deference to the initial Claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the Appeal, the Claimant will have the right to learn the identity of such individual.

Interim Notification of New Evidence or Rationale during pendency of Internal Appeal

If during the pendency of the Claim or Appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the Claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the Claim on Appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a Claim on Appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the Claim on Appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Notification of Final Internal Decision on Appeal

After an Appeal is filed, the Claims Reviewer will respond to the Claim within a certain period of time. The amount of time that the Claims Reviewer has to respond is based on the underlying Claim for benefits as set forth below:

- *Post-Service Claims:* Within a reasonable period, but no more than 60 days after receiving Claimant's Appeal request
- *Pre-Service Claims:* Within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving Claimant's Appeal request
- *Urgent Care Claims:* As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving Claimant's Appeal request (the Plan will defer to the attending provider with respect to the decision as to whether a Claim is an Urgent Care Claim)

If the Claim on Appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- sufficient information to identify the Claim involved, including the date of service, the health care provider, and if applicable, the Claim amount;

- references to the specific Plan provisions on which the benefit determination was based;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the Claim for benefits;
- a description of any voluntary review procedures, internal Appeals and the external review process, including information on how to initiate an Appeal and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the Claim;
- a discussion of the decision to deny the Claim;
- disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793; and
- a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal or external review.

External Review of Benefit Claims

These procedures are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01, Department of Labor Technical Release 2011-02, and 76 Fed. Reg. 37208-37234 (June 24, 2011). At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with PPACA.

Standard External Review

This section describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

Requests for External Review. A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. External review is only available for:

- A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
- An adverse benefit determination (including a final adverse benefit determination) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a Claim is considered to involve medical judgment include adverse benefit determinations based on:
    - The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);

- Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
- Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
- A determination that a medical condition is a preexisting condition;
- The Plan's and/or benefits plan's general exclusion of an item or service, if the Plan and Plan covers the item or service in certain circumstances based on a medical condition;
- Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's or a Plan's wellness program, if any;
- The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
- Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

Preliminary Review. Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility Claims are not subject to external review);
- The Claimant has exhausted the Plan's internal Appeal process unless the Claimant is not required to exhaust the final internal Appeals process; and
- The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

Referral to Independent Review Organization. The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally-recognized accrediting organization to conduct the external review. The Claims Reviewer will contract for assignments under the Plan with at least three IROs. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.
- Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the Claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal Claims and Appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - The Claimant's medical records;
    - The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;
    - The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;
    - Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
    - Any applicable clinical review criteria developed and used by the Plan or Plan, unless the criteria are inconsistent with the Plan's or Plan's terms or with applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.
- The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, and if applicable, the Claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
    - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;
    - A statement that judicial review may be available to the Claimant; and
    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the Claim or otherwise providing benefits at any time, including after a final external review decision that denied the Claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the Claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

Request for Expedited External Review. When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal Appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal Appeal, or
- A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant receive emergency services, but has not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in the section above for *Standard External Review*. The Plan must immediately send a notice that meets the requirements set forth in the section above for Standard External Review to the Claimant of its eligibility determination.

Referral to Independent Review Organization. Upon determination that a request is eligible for expedited external review following preliminary review described above, the Claims Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in the section above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the IRO will review the Claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal Claims and Appeals process.

Notice of Final External Review Decision. The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of the section above for *Standard External Review*, except that the notice will be provided as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.

Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the Claim or otherwise providing benefits at any time, including after a final external review decision that denied the Claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the Claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

All Other Claims

The Plan Administrator shall maintain this procedure under which any Participant (or an authorized representative acting on behalf of a participant) may assert a Claim for benefits not covered by the Claims procedures for health benefits set forth above. Any such Claim shall be submitted to the Claims Reviewer in writing. The Claims Reviewer will generally notify the Claimant of its decision within 90 days after it receives the Claim. However, if the Claims Reviewer determines that special circumstances require an extension of time to decide the Claim, it may obtain an additional 90 days to decide the Claim. Before obtaining this extension, the Claims Reviewer will notify the Claimant in writing, and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Claims Reviewer expects to render a decision.

If the Claim is denied in whole or in part, the Claims Reviewer will provide the Claimant with a written notice which explains the reason or reasons for the decision, includes specific references to Plan provisions upon which the decision is based, provides a description of any additional material or information which might be helpful to decide the Claim (including an explanation of why that information may be necessary), and describes the Appeals procedures and applicable filing deadlines, and if applicable, the right to bring a civil legal action under ERISA if the Claim continues to be denied on review. It will also include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the Claim for benefits. If the Claimant disagrees with the decision reached by the Claims Reviewer, the Claimant may submit a written Appeal requesting a review of the decision. The written Appeal must be submitted within 60 days of receiving the initial adverse decision. The Appeal should clearly state the reason or reasons why the Claimant disagrees with the Claims Reviewer's decision. The Claimant may submit written comments, documents, records and other information relating to the Claim even if such information was not submitted in connection with the initial Claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the Claim. The Claims Reviewer will generally notify the Claimant of its decision on Appeal within 60 days after the Appeal is received, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision will be in writing and will include specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based; and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. It will also describe any voluntary Appeal procedures and applicable time limits, a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and, except in the case of the Commuter/Transit Benefit and the Dependent Care Flexible Spending Account, the right to bring a civil legal action under ERISA.

APPENDIX B—Medicare Part D Notice of Creditable Coverage

Important Notice from The Saratoga Hospital Health Benefits Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Employer has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will be affected. If you elect Part D coverage, coverage under this plan, including both medical and prescription drug coverage, will end for you and all of your covered dependents. This Plan will not coordinate its coverage with the Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Is the Plan Coverage also Creditable Coverage for Purposes of Medicare Part B?

Not necessarily. This notice only addresses whether the Plan coverage is creditable for purposes of Medicare Part D. Similar concepts apply, however, for Medicare Part B.

For example, if you do not enroll for Medicare Part B at your earliest opportunity, then you will need to wait until the next annual enrollment period before you will have another opportunity to enroll for coverage, and when you do enroll you will have to pay a premium penalty, unless you have had creditable coverage in the interim. For purposes of Medicare Part B, creditable coverage means:

- employer group health plan coverage that is provided to you in connection with your own current employment status; and
- employer group health plan coverage that is provided to you in connection with your spouse's current employment status.

Coverage is considered to be in connection with an employee's current employment status if the eligible employee is actively working. Coverage is not in connection with an employee's current employment status if the eligible employee is retired, if the eligible employee terminates employment and elect COBRA continuation coverage, if the eligible employee is absent from work due to disability in excess of six months, or for employees who have been receiving Medicare due to End Stage Renal Disease in excess of 30 months.

For Medicare Part B purposes, coverage generally is not creditable if it is provided by a domestic partner's employer. Domestic partners generally will be required to enroll in Medicare Part B at their earliest opportunity (otherwise they will not have special enrollment rights if other coverage is lost and they will have to pay a premium penalty). There is an exception in some cases if the domestic partner is eligible to enroll in Medicare due to disability (rather than age) and if the employer sponsoring the health plan employs 100 or more employees.

Contact Medicare at the number(s) below for more information about Medicare Part B special enrollment periods and premium penalties.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare cription drug coage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra h visit Social Security the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11/19/2020
Name of Entity/Sender:	Saratoga Hospital
Contact—Position/Office:	Human Resources Benefits
Address:	211 Church St, Saratoga Springs NY 12866
Phone Number:	518-583-8435

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3100

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