PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN
www.ssehp.org

Revision Date: October 1, 2023

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INTRODUCTION

This document is a description of Suffolk School Employees Health Plan (the Plan). No oral interpretations can change this Plan.

We continue to review our plan on a consistent basis to ensure we are offering you and your family the benefits and services that support your health care needs. We also monitor the national economic impact on health care, as well as how our benefits compare to equivalent health plans on Long Island.

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

This Summary Plan Description, which is also your Certificate of Benefits, describes in detail the health benefits coverage provided by the Suffolk School Employees Health Plan. The Plan is coordinated by United Healthcare and includes the following basic elements of coverage:

- Hospitalization and Medical Coverage administered by UnitedHealthcare
- Prescription Drug Coverage for both Retail and Mail Order administered by OptumRx

You should familiarize yourself with the Suffolk School Employees Health Plan by reading this Summary Plan Description so that you will be able to use the benefits it provides most effectively.

Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy the waiting period and all the eligibility requirements of the Plan.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, prior notification requirements, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Claims Administrator.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to covered charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered employees and their dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Coordination with Medicare. Shows the Plan payment order when a person is covered under Medicare.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a covered person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

In its sole discretion, the Claims Administrator shall resolve all questions concerning the administration, interpretation or application of the Claims, subject to appeal to the Board of Trustees.

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

If you want information about any aspect of the Suffolk School Employees Health Plan, or if you need assistance in resolving a problem, you should first contact your District's Benefits Administrator. The District's Benefits Administrator can assist you in obtaining full information concerning your personal enrollment status as well as the eligibility requirements and benefit provisions of all enrollment options. Your District's Benefits Administrator can also assist you in resolving any claims problems you may encounter.

You Have Questions About the Suffolk School Employees Health Plan:

- You have questions concerning your family's eligibility for health coverage
- You have questions about changing your type of coverage (family/individual)
- Your employee benefit identification cards are lost or damaged
- You or a dependent did not receive your employee benefit identification card
- You want to know how to coordinate your Suffolk School Employees Health Plan benefits with Medicare
- You want to cancel your coverage
- Your home address changes

QUESTIONS ABOUT	CONTACT/ADDRESS	PHONE NUMBERS
• Enrollment • Eligibility	Call the District's Benefits Administrator for your school district. Smithtown South Country Schools Three Village Schools	 (631) 382-2175 (631) 730-1551 (631) 730-4034
• Benefits Management • Benefits Questions • ID Cards • Pre-Admission Certification • Second Surgical Opinion • Out-patient Mental Health, Alcoholism and Substance Use Disorder Program • Mastectomy Second Medical Opinion Program • Managed Physical Medicine Program • Hospitalization • Preferred Provider Network or to order a Network Provider Directory • Medical Claims	United Healthcare PO Box 740800 Atlanta, GA 30374-0800 www.myuhc.com/ssehp	1(866) 844-4864

Retiree and COBRA Direct Billing or Third-Party Notification	United Healthcare PO Box 740800 Atlanta, GA 30374-0800	1 (866) 844-4864
Cancer Resource Services		1 (866) 936-6002
Pharmacy	OptumRx Commercial	1-877-633-4461
Pharmacy	OptumRx Medicare	1-855-253-3270
Specialty Pharmacy Program:		See OptumRx phone numbers

GENERAL INFORMATION

WHO IS ELIGIBLE?

This section explains eligibility requirements under the Suffolk School Employees Health Plan for you (the enrollee) and your dependents. The Suffolk School Employees Health Plan has established minimum eligibility requirements, which must be met by all employees of districts that participate in the Suffolk School Employees Health Plan. However, your employer may have adopted modified rules. Please check with your personnel or business office.

MINIMUM REQUIREMENTS FOR ELIGIBILITY:

To be eligible for coverage, an employee must:

(1) Be expected to work at least the minimum period of anticipated employment required by your district, and

(2) Work a regular schedule of 20 hours or more a week, **OR**

(3) Be in one of the following categories:

- **(a)** An elected member of a school board for whom the Board of Education has authorized participation in the Plan.
- **(b)** Be paid an annual salary at a rate of $2,000 or more per year, **OR**
- **(c)** Receive your major source of family income from employment with the employer.

(4) Not already enrolled in the Suffolk School Employees Health Plan as an employee of another participating district, which is part of this Plan. Depending upon your district's contractual agreements, you may be eligible for family coverage if you are enrolled under the program as a dependent in another participating district that is part of the Suffolk School Employees Health Plan. Please check with your District's Benefits Administrator.

Note: These minimum requirements may be modified.

YOUR DEPENDENTS:

The following dependents are eligible for Suffolk School Employees Health Plan coverage:

(1) *Your spouse, including a legally separated spouse, is eligible.* If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.

(2) *Domestic Partner.* Subject to agreement by collective bargaining within each district.

(3) Your children under 26 years of age are eligible to the end of the month in which they turn 26. This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren.

If you apply for coverage on behalf of a dependent whose last name is different from yours or who is other than your spouse or own child, you must complete a Statement of Dependence Form and submit it to your district office for approval.

(4) Military Service: For purposes of eligibility for health coverage, you may deduct up to four years from your dependent's age for active duty in a branch of the U.S. Military.

(5) *Disabled Dependents*: Your dependent children who are eligible for coverage under this Plan, and who are incapable of supporting themselves because of a mental or physical disability acquired before termination of eligibility for health care are eligible. For example, if your child becomes disabled while eligible, the child may qualify to continue coverage as a disabled dependent.

If you have a child who qualifies for coverage as a disabled dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file a Disabled Dependent Form. Contact your District's Benefits Administrator several months before your child's coverage terminates.

If your child is eligible for coverage and becomes disabled, you should file a Disabled Dependent Form at the time the disability occurs.

(6) *Young Adult Option*: Young adults may obtain individual coverage up until the last day of the month in which they turn 30 but they will be responsible for the full premium of both employer and employee costs.

Continuation of coverage for unmarried dependent children who have reached maximum age under the parent's group health plan is available to them by contacting the District's Benefits Administrator, completing an enrollment form and making payment. It is not a requirement to be financially dependent on the parent to elect this benefit. Continuation of coverage may continue through age 29 unless they are otherwise entitled to coverage under Medicare or covered under another group health insurance, in which case they will not qualify for continuation of coverage under this plan.

Coverage terminates when:

- the period of continuation coverage has elapsed;
- policy coverage would have otherwise ended;
- payment is discontinued; or
- the employer's participation in the group plan is terminated and the plan is not replaced.

If the dependent child falls out of SSEHP's definition but later re-qualifies as a dependent (for example, becomes divorced or is no longer eligible for employer group health coverage), he or she may again elect dependent continuation coverage within 60 days of meeting the eligibility requirements or during annual open enrollment periods.

If you have any questions concerning eligibility, please contact your District's Benefits Administrator.

DISQUALIFICATION PROVISION

The Plan reserves the right to pursue legal action against a covered individual suspected of fraud, deception, false statements of a material fact, or accepting benefits for himself, herself, or a dependent knowing he/she or such dependent was not entitled to such benefits. Reimbursement to the Plan by a covered individual of benefits obtained improperly fraudulently, or by deceit, shall not waive the right of the Plan to pursue legal action against said individual.

GENERAL FRAUD PROVISION

Stop Health Care Fraud!

Fraud increases the cost of health care of everyone and increases your Health Benefit Plan contributions. All allegations of fraud, waste, and abuse in the Plan will be investigated.

Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized Plan representative. Let only the appropriate medical professionals review your medical record or recommend services. Report fraud to the Claims Administrator.

ENROLLMENT

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

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

To enroll for coverage, contact your District's Benefits Administrator.

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

WHEN COVERAGE BEGINS: Your district establishes the date on which an employee becomes eligible for coverage.

HOW CHANGES IN YOUR STATUS AFFECT COVERAGE

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

LEAVE WITHOUT PAY:

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

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

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

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

Suspending Coverage While Off of the Payroll: You may suspend your health coverage for the time you are on Leave Without Pay. Arrange for the suspension with your District's Benefits Administrator BEFORE your last day of work. You will not be required to submit any premium payments. Your coverage will end on the last day of the month in which you request suspension.

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

Reinstatement after Cancellation - If your insurance is cancelled for non-payment of premium, you may appeal to the Board of Trustees for reinstatement. Reinstatement is at the sole discretion of the Trustees.

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

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

Please check with your school district office for eligibility information. If a waiting period is required by the school district, there is no coverage until such waiting period has been met.

HOW TO CANCEL ENROLLMENT:

To cancel your enrollment in the Suffolk School Employees Health Plan or to cancel coverage for a dependent, see your District's Benefits Administrator to complete the necessary form.

Third -Party Notification Form provides a vehicle for contact information for you to be used in theevent you are unable to pay your health care costs. Prior to cancellation of coverage, possible outreach assistance may be provided on your behalf informing of financial hardship.

COVERAGE: INDIVIDUAL OR FAMILY

Two types of coverage are available to you under the Suffolk School Employees Health Plan:

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

FAMILY COVERAGE provides benefits for you and your eligible dependents. To enroll yourself and your dependents in family coverage, you must provide each person's date of birth and other information to the Suffolk School Employees Health Plan through your District's Benefits Administrator.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE:

If you qualify for a change from individual to family coverage and you want family coverage, contact your District's Benefits Administrator. This would apply to a change in family status or a loss of spouse's coverage.

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

(1) You acquire a new dependent (for example, you marry or have or adopt a child), **OR**

(2) Your spouse's other health insurance coverage ends.

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

Written proof of the event must be submitted to your District's Benefits Administrator.

Your new coverage begins:

(1) If you apply on or before the date of the event, your family coverage will be effective on the date of the event.

(2) If you apply within one month after the event, there will be a waiting period. Your family coverage will become effective on the first day of the month following your application.

(3) If you apply more than one month after the event, there will be a longer waiting period. Your family coverage will become effective on the first day of the third month following the month in which you apply.

You must apply within one month of the event in order to avoid a three-month waiting period.

Considered late if previously eligible: If you change to family coverage in order to include your spouse or dependents who were **previously eligible** but not enrolled, their coverage will begin on the first day of the third month following the month in which you apply.

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

The effective date of coverage depends upon the reason for the change and the prompt notification to the Plan of such change.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE:

You must change to individual coverage when you no longer have **any** eligible dependents.

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

Contact your District's Benefits Administrator for information about when your dependents' coverage ends if you change from family to individual coverage.

WAIVER OF PREMIUM

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

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

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

(2) You must be on authorized Leave Without Pay. You are **NOT** eligible for the waiver if you are still receiving income through salary, sick leave accruals or retirement allowance.

(3) You kept your coverage in effect while you were off the payroll by paying the required full cost of your health benefit premium (your contribution and your District's contribution, if any) if you are on an approved leave without pay.

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

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

(1) You return to the payroll.

(2) You are no longer on a Preferred List.

(3) You are no longer disabled.

(4) You are no longer a district employee (and are not on a preferred list).

(5) You vest your health coverage rights.

(6) You retire.

(7) You die.

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

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

LAYOFF AND PREFERRED LIST:

If you are laid off and your name has been placed on a Department of Civil Service Preferred Eligible List, you may be able to continue your health coverage for a limited period of time. Contact your District's Benefits Administrator for information on whether your district offers this optional program feature.

CONTINUING COVERAGE WHEN YOU RETIRE OR VEST

Most districts permit enrollees who have met certain eligibility requirements to continue their coverage after retirement and may require you to contribute to the cost of such coverage. These requirements vary from district to district. **You should contact your District's Benefits Administrator for specific details of the rules of your employer.** The following information may be used as a general guideline.

ELIGIBILITY FOR RETIREE COVERAGE:

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

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

If you are not a member of such a retirement system and are at least 55 years of age and if last entry into service was PRIOR TO September 1, 1983, OR you are 62 years of age and if last entry occurred ON OR AFTER September 1, 1983, you may also be eligible for retiree coverage, **AND**

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

These provisions do not apply to all districts included in the Suffolk School Employees Health Plan. Please contact your District's Benefits Administrator to determine your benefit coverage in retirement.

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

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

DISABILITY RETIREMENT:

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

In the case of a disability retirement resulting from a work-related Illness or Injury, the age requirement and the minimum service requirement are waived. Check with your District's Benefits Administrator for further information.

SUMMARY:

Before You Retire:

- Check the requirements for continuing your health benefits in retirement.
- If you are eligible to continue your health insurance benefits, ask your District's Benefits Administrator to update your enrollment information.
- Contact your Social Security Administration office two or three months before you or a Dependent turns 65 to find out about enrolling in Medicare.
- If you are moving, please notify your district office.

VESTING:

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

(1) you have satisfied the minimum requirements established by law for vesting your retirement allowance; **AND**

(2) you have met all the minimum requirements, except age, for continuation of health coverage in retirement at the time employment is terminated. In addition, the participating district, which has elected to continue coverage for its retirees, may require that you be within five years of retirement at the time you vest.

To continue coverage as a vestee, be sure to contact your District's Benefits Administrator to arrange for continuation.

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

In no case may the value of sick leave credits be applied toward health premium costs either while you are in vested status or after you become eligible to retire. Each district, may, by contract, allow you to apply all or a part of the value of your sick leave credits toward your premium if you retire directly from active employment. Please check with your District's Benefits Administrator.

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

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

COVERAGE FOR YOUR DEPENDENT SURVIVORS

Extended Benefits Period at No Cost: The Suffolk School Employees Health Plan protects your survivors if you should die. If you die while you are enrolled in the Suffolk School Employees Health Plan as a participating district employee, vestee, or retiree, your UNREMARRIED enrolled spouse and enrolled dependent children will continue to receive coverage for an extended benefit period of three months following the month in which the enrollee's death occurred at no cost to the survivor(s). However, in no case will extended benefits continue more than three months following the month in which the enrollee dies.

If you die while you are enrolled in the Suffolk School Employees Health Plan your enrolled dependents will be eligible for continuation of coverage or conversion to a direct payment contract through the State Continuation Coverage Law or COBRA.

Coverage After the Extended Benefits Period Ends: Coverage can be extended beyond the extended benefits period at a cost to the enrollee. If you have completed 10 or more years of service, your UNREMARRIED spouse and eligible dependent children will be allowed to continue their coverage under the Suffolk School Employees Health Plan after the extended benefit period ends.

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

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

For information on the cost of dependent survivor coverage, contact your District's Benefits Administrator.

Coverage For Your Eligible Dependents if Your Spouse Loses Eligibility or Dies: If your surviving spouse dies, your other eligible dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. If they no longer meet these requirements, they may be eligible to enroll through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

If Your Family is Not Eligible for Dependent Survivor Coverage: If your spouse and dependents are not eligible for survivor coverage under the Suffolk School Employees Health Plan, they may be eligible to continue their coverage in the Suffolk School Employees Health Plan for a limited time under COBRA. See your District's Benefits Administrator for further information.

CONTINUATION OF COVERAGE

Continuation of coverage for unmarried dependent children who have reached maximum age under the parent's group health plan is available to them by contacting the District's Benefits Administrator,

completing an enrollment form and making payment. It is not a requirement to be financially dependent on the parent to elect this benefit. Continuation of coverage may continue through age 29 unless they are otherwise entitled to coverage under Medicare in which case they will not qualify for continuation of coverage under this plan.

Coverage terminates when:

- the period of continuation coverage has elapsed;
- policy coverage would have otherwise ended;
- payment is discontinued; or
- the employer's participation in the group plan is terminated and the plan is not replaced.

If the dependent child falls out of SSEHP's definition but later re-qualifies as a dependent (for example, becomes divorced or is no longer eligible for employer group health coverage), he or she may again elect dependent continuation coverage within 60 days of meeting the eligibility requirements or during annual open enrollment periods.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your District's Benefits Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's ex-spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of employment, for any reason other than gross misconduct.

B. A reduction in the Participant's hours of employment that causes the Participant to lose coverage under the Plan.

With respect to a Participant's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).

B. A reduction in the Participant's hours of employment that causes the dependent to lose coverage under the Plan.

C. Death of the Participant.

D. Divorce or legal separation of the Participant.

E. Loss of eligibility by an Enrolled Dependent who is a child.

F. Entitlement of the Participant to Medicare benefits.

G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is alsoa qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

1. Notification Requirements for Qualifying Event

The Participant or other Qualified Beneficiary must notify District's Benefits Administrator within 60 days of the latest of the following events:

- The Participant's divorce or legal separation, or an Enrolled Dependent's loss of eligibility asan Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Plan.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide noticeand the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the District's Benefits Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the District's Benefits Administrator of these events within the 60 day period, the District's Benefits Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the District's Benefits Administrator within 60 days of the birth or adoption of a child.

2. Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the District's Benefits Administrator as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to the District's Benefits Administrator at the address stated in General Plan Information in this Summary Plan Description. The contents of the notice must be such that the District's Benefits Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the District's Benefits Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the District's Benefits Administrator.

The Qualified Beneficiary's initial premium due to the District's Benefits Administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the District's Benefits Administrator for additional information. The Participant must contact the District's Benefits Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the

Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
     - the determination of the disability; or
     - the date of the qualifying event; or
     - the date the Qualified Beneficiary would lose coverage under the Plan; and
     - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the Participant's Medicare entitlement; or
   - Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

   - Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
     - the Participant's Medicare entitlement occurs within the eighteen month continuation period; and
     - if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. The other group health coverage shall be primary for all health services.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitledto continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

I. The date coverage would otherwise terminate under the Plan as per the policy of your district..

COBRA AND MEDICARE

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

KEEPING YOUR COVERAGE UP TO DATE

Changes in Your Enrollment Status: Changes in your family status make it necessary, or desirable, for you to change your type of coverage. Changes in coverage do not happen automatically. You must submit a form to the District’s Benefits Administrator of any changes, such as:

Your Family Coverage:

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

Your Status Changes:

- You are going to retire from your district.
- You are affected by a layoff.
- You are going on leave without pay.
- You want to continue your health coverage while in vested status.
- You become disabled and want to apply for a Waiver of Premium.
- You want to cancel your health coverage to obtain dependent status under your spouse’s Suffolk School Employees Health Plan coverage.

SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT	Unlimited per Lifetime	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE PER CALENDAR YEAR		
Per Covered Person	N/A	$1000
Maximum Per Family	N/A	$3000
COINSURANCE: the difference between the **110%** of the published rates allowed by the *Centers for Medicare and Medicaid Services* Charge and the covered percentage under the non-network providers portion of this Plan.		
The Plan will pay the designated percentage of Covered Eligible Expenses until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Eligible Expenses for the rest of the Calendar Year.		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Per Covered Person	$7,350 single $14,700 Family	$4,000 single $8,000 family (Deductible is NOT included)
COPAYMENT/COINSURANCE	Contracted Rate	(110% of Medicare)
Hospital services - Inpatient	$100 per confinement	$100 per confinement
Emergency Room Outpatient services	$70	Same as Network
Ambulatory Surgical Facility (non-hospital)	$30	80% of Eligible Expenses after the deductible
Ambulatory Surgery (hospital)	$60	80% of Eligible Expenses after the deductible
Urgent Care Center Services	$25	80% of Eligible Expenses after the deductible
PCP* Physician visits Specialist** Physician visits Virtual Visits	Non Tier 1 PCP $25 Tier 1 Premium provider $20 Non Tier 1 Specialist $30 Tier 1 Premium Specialist $25 Non-Premium orthopedic visits $50 100% of Eligible Expenses after $15 Copay	80% of Eligible Expenses after the deductible Not Covered
Lab Outpatient Hospital	$40	80% of Eligible Expenses after the deductible
Lab/Radiology/X-Ray Alternate Facility	$25	80% of Eligible Expenses after the deductible
Non-Network Non-Notification Penalty (prior authorization)	N/A	$200

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
*PCP (Primary Care Physicians) - include general practice, internal medicine, family practice, pediatrics and OB/GYN's. **Specialists - examples of Specialists include cardiologists, oncologists, chiropractors, dermatologists, orthopedists and physical therapists.		
Hospital Services		
Room and Board and Ancillary (Prior Notification required for Non-Network benefits) You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.	100% of Eligible Expenses after copayment at the semiprivate room rate	Same as Network **Notify Care Coordination for Non-Network Services** Please remember that you must notify Care Coordination as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within 48 hours of admission, or as soon as is reasonably possible.
Cancer Resource Services 1-866-936-6002	100% of Eligible Expenses after applicable copay A voluntary program that offers patients access to a network of facilities and providers that specialize in the treatment of cancer. Contact Member Services for further information.	Only available In Network
Obesity Surgery The use of the Bariatric Resource Services (BRS) Centers of Excellence is mandatory under the Plan benefits.	100% of Eligible Expenses subject to meeting criteria	Only available In Network

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Skilled Nursing Facility (Prior Notification required for Non-Network benefits)	100% of Eligible Expenses	100% of Eligible Expenses **Notify Care Coordination for Non-Network Services** Please remember that you must notify Care Coordination as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within 48 hours of admission, or as soon as is reasonably possible.
Physician Services		
Inpatient visits	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Injections **Allergy Injections** No copayment if no charge is made for the office visit.		
Second Surgical Opinion is covered under physician services This is not a required service to obtain benefits.		
Podiatry **Covered benefit:** Podiatry benefit is a covered service with the exception of routine care of the feet, UNLESS needed in treatment of a metabolic or peripheral-vascular disease. See *Foot Care*. **Exclusions:** Foot care- Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations for bunions only), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).		
Home Health Care Benefit is limited to up to 4 hours per day	100% of Eligible Expenses	**Not covered**
Outpatient Private Duty Nursing **Please see Home Health Care Benefit**	100% of Eligible Expenses covered subject to Home Health Care above	**Not covered**

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care (Prior Notification required for Non-Network benefits) Life expectancy of six months or less must be certified by Hospice Organization Network and Non-Network Benefits are unlimited. Hospice Bereavement Counseling up to one year	100% of Eligible Expenses, no deductible	100% of Eligible Expenses, no deductible **Notify Care Coordination** • Please remember that for Non-Network Benefits you should notify Care Coordination five business days before receiving services.
Ambulance Service Non-emergency ambulance services covered same as emergency ambulance services. Eligible Expenses for Emergency ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	Ground Transportation 100% of Eligible Expenses of first $50.00 then 80% of R&C Air Transportation 100% of Eligible Expenses of first $50.00 then 80% of R&C	Ground Transportation 100% of Eligible Expenses of first $50.00 then 80% of R&C Air Transportation 100% of Eligible Expenses of first $50.00 then 80% of R&C
Wig after Chemotherapy Limited to 1 per diagnosis	100% of Eligible Expenses, deductible waived	100% of Eligible Expenses deductible waived
Physical Therapy **Occupational Therapy** **Restorative Speech Therapy** **Pulmonary Rehabilitation** **Cardiac Rehabilitation** Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. **The following service is not covered:** Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or a Congenital Anomaly.	$25 per visit 100% of Eligible Expenses after copayment	80% of Eligible Expenses after the deductible
Reconstructive Procedures		
Inpatient	100% of Eligible Expenses after hospital copayment	80% of Eligible Expenses after the deductible
Outpatient	100% of Eligible Expenses after office visit copayment	80% of Eligible Expenses after the deductible
You can contact Care Coordination at the telephone number on your ID card for more information about Benefits for mastectomy related services. **Breast reduction surgery** is a covered benefit if deemed necessary due to medical reasons.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
The following services are not covered: • Cosmetic Procedures. • Pharmacological regimens, nutritional procedures or treatments. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and otherskin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. NOTE: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.		
Gynecomastia		
Inpatient	100% of Eligible Expenses after hospital copayment	80% of Eligible Expenses after the deductible
Outpatient	100% of Eligible Expenses after office visit copayment	80% of Eligible Expenses after the deductible
Pre-Surgical Testing Services	100% of Eligible Expenses after office visit copayment	80% of Eligible Expenses after the deductible
Outpatient Surgery, Diagnostic and Therapeutic Services	100% of Eligible Expenses for Outpatient Surgery, Diagnostic Services, Diagnostic Therapeutic Services –CT Scans, Pet Scans, MRI and Nuclear Medicine and Therapeutic Treatments, pre-surgical testing ***For routine mammography testing:*** **100%** (No copay/ No deductible regardless of Place of Service). ***For non-routine mammography testing:*** **100%** of Eligible Expenses (No copay/ No deductible regardless of Place of Service) No Age schedule should apply.	80% of Eligible Expenses after the deductible for Outpatient Surgery, Diagnostic Services, Diagnostic Therapeutic Services –CT Scans, Pet Scans, MRI and Nuclear Medicine and Therapeutic Treatments, pre-surgical testing ***For routine mammography testing:*** **100% of Eligible Expenses**. (No copay/ No deductible regardless of Place of Service). ***For non-routine mammography testing:*** **100%** of Eligible Expenses (No copay/ No deductible regardless of Place of Service) No Age schedule should apply.
	For routine and non-routine Colonoscopy and Endoscopy testing: **100%** of Eligible Expenses (No copay/ No deductible regardless of Place of Service)	***For routine and non-routine Colonoscopy and Endoscopy testing:*** **100%** of Eligible Expenses. (No copay/ No deductible regardless of Place of Service)
Acupuncture Services Covered for pain management only.	100% of Eligible Expenses after copayment.	Not covered out of Network

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Dental Services – Accident Only Care must be rendered within 12 months of the injury) (Prior Authorization required) **Notify Care Coordination** • Please remember that you must notify Care Coordination as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.)	90% of Eligible Expenses	80% of Eligible Expenses after the deductible
Durable Medical Equipment (Prior Notification required for Non-Network Services) Network and Non-Network Benefits for Durable Medical Equipment have no annual maximum.	90% of Eligible Expenses	80% of Eligible Expenses after the deductible **Notify Care Coordination** • Please remember that for Non-Network Benefits you must notify Care Coordination before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).
Ostomy Supplies **The following supplies are covered:** • Pouches • Face plates • Belts • Irrigation Sleeves, Bags, & Catheters • Skin Barriers	90% of Eligible Expenses	80% of eligible expenses after the deductible
The following supplies are not covered: • Gauze • Adhesives and adhesive removers • Deodorant • Pouch covers Any other item not listed as covered		
Prosthetics	100% of Eligible Expenses	100% (deductible waived)

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Shoe Orthotics (shoe inserts)	100% of Eligible Expenses up to $500.00 every three (3) years for adults and up to $250.00 once every year for children 12 and under.	80% of eligible expenses after the deductible up to $500 every three (3) years for adults and up to $250.00 once every year for children 12 and under.
Spinal/Chiropractic Services Benefits include diagnosis and related services and are limited to **one** visit per day.	100% of Eligible Expenses after copayment Network benefits are unlimited.	Out of Network manipulative services are not covered.
Mental Health Disorders		
Inpatient	100% of Eligible Expenses after hospital copayment	100% of Eligible Expenses after hospital copayment
Outpatient	100% of Eligible Expenses after office visit copayment	80% of eligible expenses after the deductible
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient	100% of Eligible Expenses after hospital copayment	100% of Eligible Expenses after hospital copayment
Outpatient	100% of Eligible Expenses after office visit copayment	80% of Eligible Expenses after the deductible
Substance Use Disorders		
Inpatient Rehab Residential Treatment is covered	100% of Eligible Expenses after hospital copayment	100% after hospital copayment
Outpatient	100% of Eligible Expenses after office visit copayment	80% of Eligible Expenses after the deductible
Preventive Care		
Routine Health Exams	100% of Eligible Expenses	80% of Eligible Expenses after deductible
Includes: office visit, pap smear, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, and immunizations/flu shots.		
Mammogram	100% of Eligible Expenses	100% of Eligible Expenses
Routine Well Newborn Care	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Routine Well Child Care	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Routine Adult Care (includes an annual exam and an annual ob-gyn exam)	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Includes: office visit, routine physical examination, laboratory blood tests, x-rays, hearing tests, and immunizations.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Organ Transplants (Donor coverage is available if the recipient is covered under the Plan)	Hospital - 100% of Eligible Expenses Surgeon - 100% of Eligible Expenses Network Benefits for transplants must be performed at United Resource Network (URN) Transplant Centers or at any UHC Designated facility United Resource Network includes medical centers of excellence that specialize in the transplant process You may contact Member Services for a listing of United Resource Network Transplant Centers and information on mandatory participation in the United Resource Network Transplant Program	**Not covered out of network**
Pregnancy	100% of Eligible Expenses after copayment	80% of Eligible Expenses after the deductible
Chemotherapy	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Radiation treatment	100% of Eligible Expenses	80% of Eligible Expenses after the deductible
Dialysis and/or Hemodialysis	100% of Eligible Expenses	Not covered
Infertility Services through Fertility Solutions	100% of Eligible Expenses after copayment (must use UnitedHealthcare's Center of Excellence to receive benefits) $25,000 Lifetime maximum, excluding medications covered under the Outpatient Pharmacy benefit.	Not covered
Hearing Aid Coverage Reimbursed up to $2,500 maximum per ear every 36 months. Includes examination for and fitting of hearing aids. (Every two years for children under age 12.) Not subject to the copayment, deductible or coinsurance. Repairs not covered.	100% of Eligible Expenses	100% of Eligible Expenses

MEDICAL NECESSITY

Medical Necessity/Prior Authorization

The Medical Necessity Care Management model provides you with an opportunity to enhance quality of care and reduce health care cost. Some of the key components to support this approach include:

Medical Necessity - Medical Necessity is the process of determining benefit coverage and/or provider payment for services, tests, or procedures which are medically appropriate and cost-effective for the individual member.

Prior Authorization – Suffolk School Employees Health Plan requires prior authorization for certain Covered Health Services. In general, physicians and other health care professionals who participate in the Network are responsible for obtaining prior authorization. **However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.**

It is recommended that you confirm with UnitedHealthcare that the Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the hospital, physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

To obtain prior authorization for an out-of-network service and to confirm how far in advance you are required to initiate the process, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this SPD Schedule of Benefits, Medical Benefits and Prescription Drug Benefit.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility.
- Not otherwise excluded in this SPD under Exclusions and Limitations or Prescription Drug Benefit.

Member Prior Authorization Requirements – Non-Network

- Accidental Dental
- Ambulance non-emergent air and ground
- BRCA testing (breast cancer susceptibility)
- Clinical Trials
- Congenital Heart Disease Surgeries
- Durable Medical Equipment (DME) – greater than $1000 either retail purchase cost or cumulative retail rental cost))
- Home Health Care
- Hospice – inpatient
- Hospital – inpatient all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Mental Health /Neurobiological Disorders – Autism Spectrum Disorder/Substance Use Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Prosthetic Devices over $1,000
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Sleep apnea surgeries
- Therapeutics only for the following services: intensity modulated radiation therapy, and MR-guided focused ultrasound. (outpatient), IV infusion and radiation oncology

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

MEDICAL BENEFITS

All benefits described in this section are subject to the exclusions and limitations described more fully herein including, but not limited to services, supplies and care that are not experimental and/or investigational. The meanings of these terms are in the Defined Terms section of this document. These benefits may change from time to time. Please be sure to read all Plan Bulletins for such changes as they occur.

The Plan is a Choice Plus Plan with Network Providers.

Choice Plus name: United Healthcare Choice Plus Plan

Address: PO Box 740800
Atlanta, GA 30374-0800
Telephone: (866) 844-4864

This Plan has entered into an agreement with certain hospitals, physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Under the following circumstances, the higher in-network payment will be made for certain non-network services:

- If a covered person is out of the Network service area and has a medical emergency requiring immediate care.

Additional information about this option, as well as a list of Network Choice Plus Plan Providers, will be given to plan participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the covered person must pay before the Plan pays.

A deductible is an amount of money that is paid once a calendar year per plan participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services rendered by Non-Network providers. Each January 1st, a new deductible amount is required.

A copayment is a smaller amount of money that is paid each time a particular service is rendered by Network providers. There may be copayments on some services while other services will not have any copayments.

Coinsurance is the amount the Plan will pay for Covered Eligible Expenses until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Eligible Expenses for the rest of the Calendar Year.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described under Eligible Expenses in this section. As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount UnitedHealthcare determines to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

Covered Health Services that are provided at a Network facility by a non-Network facility-based Physician, when not Emergency Health Services, will be reimbursed as set forth under Eligible Expenses as described under Eligible Expenses in this section. As a result, you will be responsible for the difference between the amount billed by the non-Network facility-based Physician and the amount UnitedHealthcare determines to be an Eligible Expense for reimbursement. The payments you make to non-Network facility-based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

Eligible Expenses

For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:
  - 50% of CMS for the same or similar freestanding laboratory service.
  - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
- When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility-based Physician, the Eligible Expense is based on 50% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within

the geographic market with the exception of the following:

- 50% of *CMS* for the same or similar freestanding laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment from a freestanding supplier, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.

Refer to UnitedHealthcare's website at [**www.myuhc.com**] for information regarding the vendor that provides the applicable gap fill relative value scale information**.**

For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

BARIATRIC RESOURCE SERVICES (BRS)

The Plan covers surgical treatment of morbid obesity provided all of the following are true:

- you are over the age of **18** or, for adolescents, have achieved greater than **95%** of estimated adult height AND a minimum Tanner Stage of **4**
- you have a minimum Body Mass Index (BMI) of **40**, or > **35** with at least **1** co-morbid condition present
- you have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation
- 6-month physician supervised diet documented within the last 2 years
- Excess skin removal post bariatric surgery is not covered, unless medically necessary

All authorization information and enrollment for bariatric surgery should be initiated through Optum's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at **(888) 936-7246** to enroll in the program.

CANCER RESOURCE SERVICES (CRS)

- Access to the CRS Centers of Excellence Network gives patients care thatis planned, coordinated and provided by a team of experts who specialize in their specific cancer. Potential benefits include accurate diagnosis, appropriate therapy (neither too little nor too much), higher survival rates and decreased costs.
- Network benefits are available for patients who receive care at a designated CancerResource Services Network facility.
- Participation in this program is voluntary for the enrollee. To ensure network benefits are received under this program, patients, or someone on their behalf, must contact Cancer Resource Services at **1-866-936-6002** before receiving care. More information is also available at.**www.myoptumhealthcomplexmedical.com**.

- Coverage for Clinical Trials at a Cancer Resource Services designated facility may be covered aspart of this benefit. Please see Clinical Trials for more information.
- Travel and Lodging Assistance is available as part of the Cancer Resource Services program up to $50, per diem coverage for patient or $100 per diem for patient and one caregiver with a Lifetime Maximum of $10,000.
- Specialized Cancer Case Management Services is covered as part of this benefit. If covered refer patient to **1-866-936-6002**

Fertility Solutions

SSEHP offers benefit coverage for infertility treatment and provides access to specialty nurse services through Fertility Solutions. The use of the Fertility Solutions Centers of Excellence is mandatory under the Plan benefits.

If you are receiving or considering infertility treatment, you may call RRS from **8** a.m. to **4:30** p.m. CT, Monday through Friday, toll-free at **1-866-774-4626** (TTY: **711**) to enroll in the program and validate benefit eligibility. Once you connect with the Service, an infertility nurse will contact you within three business days to complete enrollment.

Enrollment in the program offers you access to the following specialized services:

- Infertility Nurse Services — You will have a designated infertility nurse available to you throughout your treatment process. Experienced nurses will help you select a clinic that meets your individual needs, review your treatment options, and answer treatment questions you may have.
- Infertility COE Access — You will have access to care from specialized infertility Centers of Excellence (COEs). At these COEs, patients have a higher likelihood of getting pregnant and a lower likelihood of getting pregnant with twins or triplets.

Donor Coverage: The plan will cover associated donor medical expenses, including collection and preparation of ovum and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.

HOSPITALIZATION AND RELATED EXPENSE COVERAGE
IN-PATIENT HOSPITAL CARE

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

(1) **In a Hospital:** The term “Hospital” means only an institution that fully meets every one of the following tests:

- It is primarily engaged in providing on an in-patient basis, diagnostic and therapeuticfacilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice; AND
- It continuously provides 24-hours-a-day nursing service by or under the supervisionof registered graduate nurses; AND,
- It is not a skilled nursing facility and it is not, other than incidentally, a place of rest, aplace for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

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

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

IN-PATIENT SERVICES:

Number of Days of Care: The Plan will provide care for each spell of illness for in-patient hospital care, or maternity care in a hospital or birthing center. Please refer to the Schedule of Benefits section.

A spell of illness begins when you are admitted to a hospital or birthing center.

The spell of illness ends when, for a period of at least 90 days, you have NOT been a patient in a hospital or birthing center.

Out-Patient Hospital Care and Hospice Care: Out-patient hospital care is provided whenever you meet the requirements. Hospice care is provided for the length of time that the hospice has accepted you forits program.

BED, BOARD AND GENERAL NURSING CARE:

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

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

OTHER HOSPITAL SERVICES:

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

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

MATERNITY CARE:

Maternity benefits are provided for expenses incurred in a hospital.

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

NEWBORN CHILDREN:

Benefits are available from birth for:

(1) The treatment of illness or injury

(2) Routine newborn care

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

Maternity Support Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and

advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of 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 of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, 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 vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician Fees for Surgical and Medical Services.

Surgery may be performed as open or closed surgical procedures or may be performed through

interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at www.myoptumhealthcomplexmedical.com.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

OUT-PATIENT SERVICES

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

(1) **Emergency Services:** We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Network Benefits are paid for Emergency Health Services, even if the services are provided bya non-Network provider. See Defined Terms.

Emergency Care for an Accident: The first visit for treatment of an accidental injury within 72 hours following such injury.

Emergency Care for Sudden Onset of an Illness: The first visit for treatment within 24 hours of the onset of sudden or serious illness.

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

(2) **Minor Surgery:** Benefits for follow up care at the hospital such as suture removal and check-up visits will be provided for only when billed inclusive of the initial visit.

(3) **Radiation Therapy**

(4) **Laboratory Tests:** Laboratory tests will be paid for, only if they are necessary for the

treatment and diagnosis of your illness or injury, and they are ordered by your physician.

(5) **Diagnostic X-rays:** Diagnostic X-rays will be paid for, only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your physician.

(6) **Pre-surgical Testing:** The following conditions must be met:

- The tests are ordered by a physician as a preliminary step in your admission to a hospital as a registered bed patient for surgery; **AND**
- They are necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; **AND**
- You have a reservation for the hospital bed and for the operating room before the tests are given; **AND**

(7) **Out-patient Physical Therapy:** Benefits will be provided for physical therapy in an out-patient setting only when all of the following conditions are met:

- The treatments are ordered by your physician; **AND**
- The treatments can be expected to improve the patient's condition.

(8) **Dialysis and/or Hemodialysis Treatment:** The treatments must be ordered by your physician. These benefits are in-network only.

(9) **Chemotherapy: Not subject to copayment. The treatment must be ordered by your physician.**

(10) **Mammography Screening:** Not subject to a co-payment. Mammography screening and professional component are covered as follows:

- Upon the recommendation of a physician, at any age for covered enrollees.

(11) **Administration of Deferral for Treatment of Cooley's Anemia:** Benefits will be provided for out-patient visits when it is ordered by a doctor and performed at a hospital qualified to provide this service as determined by the Plan.

(12) **Psychiatric Care in a Day or Night Care Center:** Outpatient visits will be provided for care of mental or nervous conditions in a day or night care center of an acute general or public hospital. The following conditions must be met:

- The care must be in lieu of hospitalization; and
- The program must be certified by the appropriate state agency, if the hospital is located in another state; or
- The program must be certified in New York State according to the State's mental hygiene law.

HOME HEALTH CARE

Home care benefits are available under a physician-approved plan of treatment when the necessary services are rendered through a New York State certified home health care agency. The provider outside of New York State must be a hospital or non-profit public home health care service or agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required. You are covered for 4 hours of care each day.

Covered Services Include:

- Part-time professional nursing;
- Part-Time Home Health Care services when skilled care is in place;
- Physical, Occupational or Speech Therapy;
- Medical Supplies, Drugs and Medicines prescribed by a Physician; and
- Necessary Laboratory services.

When home health care is provided through a certified agency, these additional services are covered:

- Medical Social Worker visits; and
- X-Ray and EKG services.

CARE IN SKILLED NURSING FACILITIES

Benefits are provided for covered services received in a skilled nursing facility if the patient is referred by a physician for rehabilitation treatment, and Prior Notification Requirements have been satisfied".

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

INPATIENT TREATMENT OF MENTAL HEALTH OR NERVOUS DISORDERS, NEUROBIOLOGICAL DISORDER – AUTISM SPECTRUM DISORDER SERVICES ALCOHOL AND SUBSTANCE USE DISORDERS

Care may be rendered in:

- An acute care general hospital
- A psychiatric hospital licensed by the state in which it is located
- An inpatient Substance Use Disorder Facility licensed by the state in which it is located

OUTPATIENT TREATMENT OF MENTAL HEALTH OR NERVOUS DISORDERS, NEUROBIOLOGICAL DISORDER – AUTISM SPECTRUM DISORDER SERVICES, ALCOHOL AND SUBSTANCE USE DISORDERS

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

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

NEUROBIOLOGICAL DISORDER – AUTISM SPECTRUM DISORDER SERVICES
Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) starting January 1, 2024, which are the following:

Focused on the treatment of core deficits of Autism Spectrum Disorder.

Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.

Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

MENTAL HEALTH OR NERVOUS DISORDERS, NEUROBIOLOGICAL DISORDER – AUTISM SPECTRUM DISORDER SERVICES, ALCOHOL AND SUBSTANCE USE DISORDERS

Benefits include the following levels of care:

- Inpatient treatment.
- Residential treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

Mental Health or Nervous Disorder services, Alcohol and Substance Use Disorder services and Neurobiological Disorders - Autism Spectrum Disorder services must be authorized and care overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for services.

HOSPICE CARE

Hospice care is provided for the length of time that the hospice has accepted you for its program. Network and Non-Network Benefits are unlimited.

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

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

Typically, covered hospice and out-patient services include:

- Bed patient care either in a designated hospice unit or in a regular bed, and day care services provided by the hospice organization; and
- Home care and out-patient services provided by the hospice and charged to you by the hospice are also covered. The services may include the following:
  - Bereavement counseling for the member's family, before and until one year after the member's

death;

- Drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental nature);
- Intermittent care by an RN, LPN or Home Health Aide;
- Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control of symptoms;
- Medical care provided by the hospice physician;
- Medical supplies;
- Occupational therapy;
- Physical therapy;
- Respiratory therapy;
- Respite care;
- Social services; and
- Speech therapy.

CLINICAL TRIALS

Approved Clinical Trials - An "approved clinical trial" is one that is conducted in relation to the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions. A life-threatening condition is defined as any disease from which the likelihood of death is probable unless the course of the disease is interrupted. The trial must be approved by a recognized agency.

A member is considered a qualifying individual if: (1) the member is eligible to participate in the trial according to its protocol; and (2) either a participating provider who has referred the individual to the trial concludes that participation would be appropriate, or the individual provides medical and scientific information that establishes that the individual's participation is appropriate and consistent with the trial protocol.

All medically necessary health care provided to the individual for purposes of the trial, consistent with a plan's medical coverage, and services that would be covered for those not enrolled in clinical trials will be covered. Such services include those rendered by a physician, diagnostic or laboratory tests, and other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care.

Routine patient costs do not include the actual device, equipment or drug that is being studied. Also excluded are: items and services that are provided solely to satisfy data collection and analysis needs that are not used in direct clinical management of the patient; or a service that is clearly inconsistent with the widely accepted and established standards of care for a particular disease or condition.

Coverage is limited to routine patient costs relating to cancer, cardiovascular or musculoskeletal diseases. Experimental, investigational and unproven services are excluded unless the patient's condition is life-threatening and prior approval has been obtained.

WORLDWIDE PROTECTION

Hospitalization benefits are provided anywhere in the world.

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

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

If you are required to pay a bill for services provided under your contract, submit the itemized bill along with a claim form to the Claims Administrator and you will be reimbursed according to the Plan's provisions.

Foreign International Claims are covered at the out of network level. Emergencies are covered at the network level.

NETWORK PROVIDER PROGRAM

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

There is no cost to you for services or supplies when they are covered under a Network Provider Program, except for the co-payment. At the time services are sought, patients should always ask their provider if he or she is a participant in the Third Party Administrator's Network Provider Program.

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

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

(2) **In-Hospital Physician's Visits:** You are covered for physician's office visits while an in-patient in a hospital if such visits are not related to surgery. **Benefits related to surgery are included in the scheduled amount for the surgery.**

(3) **Surgery:** You are covered for the services of physician for surgery, including post-operative care, whether performed in or out of a hospital. ***In the same visit, if you have an office visit charge and an office surgery charge, only ONE CO-PAYMENT will apply.***

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based upon 100% of the Contracted Rate for the primary procedure and 50% of the Contracted Rate for all other procedures. Any procedure that would be an integral part of the primary procedure or that is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Contracted Rate for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Contracted Rate allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 16% of the surgeon's Contracted Rate allowance and 14% for a physician's assistant..

(iv) No balance billing when an in-network provider is used.

(4) **In-Hospital Anesthesia:** You are covered for anesthesia services if such services are performed in connection with in-hospital and ambulatory surgery, maternity care or shock therapy.

(5) **Maternity Care:** You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. Payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided.

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

A. Licensed or certified to practice nurse-midwifery, and

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

(6) **Specialist Consultations:** Your physician may refer you to a specialist for a consultation. During

the consultation, the specialist will evaluate your medical condition and give you and your physician professional advice on how to proceed with your care. This specialist may or may not be a Network Provider. If you wish to use a specialist who is an In-Network Provider, you should refer to the list of providers in your area. When you use an Out-of-Network Provider, benefits are payable under the Out-of-Network portion of this Plan.

(7) **Diagnostic Laboratory and X-Ray Examinations:** You are covered for diagnostic laboratory and x-ray procedures performed out of a hospital. You are also covered for the separate interpretation of x-rays by a radiologist if the radiologist bills separately. If both diagnostic laboratory and diagnostic radiology procedures are charged by an In-Network Provider during an office visit only one copay will apply. If the diagnostic laboratory or radiology procedure is not at the same visit, **ONE** co-payment will apply toward the office visit charge and **ONE** co-payment will apply toward diagnostic services.

(8) **Chiropractors:** You are covered for visits to your chiropractor and also for necessary related x-rays. The extent of coverage will be determined by the Plan based on an ongoing review on a case-by-case basis. Coverage is subject to the Plan. **Non-Network services are not covered. Maintenance care is NOT covered.**

(9) **Visiting Nurse Services:** You are covered for part-time or intermittent visits by participating nurses or by registered nurses from accredited participating nurses services. Care must be under the supervision of a physician.

(10) **Orthotics:** Benefit is limited to $500.00 every three (3) years for adults and up to $250.00 once every year for children 12 and under.

(11) **Podiatry:** You are covered for the services of a podiatrist except for routine care of the feet.

(12) **Physiotherapy:** You are covered for the application of physio-treatment and/or treatment by osteopathic manipulation.

(13) **Radiation Therapy:** You are covered for radiation therapy given in or out of a hospital.

(14) **Shock Therapy:** You are covered for shock therapy treatments given in or out of a hospital.

(15) **Physical Therapy:** You are covered for visits to a physical therapist when the services provided are prescribed by a physician. The extent of the coverage will be determined by the Plan based on an ongoing review.

(16) **Oral and Injectable Substances:** The cost of oral and injectable substances for **routine preventative pediatric immunizations** will be a covered expense.

(17) **Acupuncture:** Coverage is subject to Plan limits.

(18) **Nutritionist:** 1 visit per Calendar Year with a physician referral.

MAJOR MEDICAL/OUT-OF-NETWORK PROGRAM

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

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

(1) First, you are liable for the deductible. It is your responsibility.

(2) After the deductible, covered medical expenses are considered for payment. You will receive the set percentage identified in the Benefit Summary Section, 80% of the **110%** of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market . You pay the remaining balance. This is called the co-insurance.

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

ANNUAL DEDUCTIBLE:

The annual deductible amount is $1000 for each covered person in each calendar year, except that:

(1) The annual deductible amount in each calendar year shall not exceed $3000 for all the members of your family combined.

(2) Only one deductible amount will apply to all covered medical expenses incurred by your family as a result of any one accident during the calendar year in which the accident occurs.

COVERAGE:

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

COVERED OUT-OF-NETWORK EXPENSES:

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

- You must notify the Claims Administrator before getting certain Covered Health Services from non-Network providers. Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.
- When you notify the Claims Administrator as described above, they will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

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

(1) Hospitals and Approved Facilities:

A. Services of hospitals for which hospitalization benefits are provided are covered excluding:

1. Any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;
2. Charges for out-patient services covered by your hospitalization;
3. Services not billed for by the hospital.

B. Services of private proprietary hospitals for the treatment of mental and nervous conditions and alcoholism are paid in full less the $100 copayment, up to the contracted rate for in-network facilities. For out-of-network facilities in-patient charges are covered at 80% of the hospital's semi-private rate less the $100 copayment.

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

REMEMBER: You must comply with the prior notification requirements for a hospital or approved facility admission.

(2) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based upon 100% of the eligible allowance for the primary procedure and 50% of the eligible allowance for all other procedures. Any procedure that would be an integral part of the primary procedure or is unrelated to a diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Eligible Expense for each surgeon's

primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Eligible Expense percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 16% of the surgeon's Eligible Expense. If a physician's assistant is required, the physician's assistant covered charge will not exceed 14% of the physician's Eligible Expense.

(3) **Physicians:** Services of physicians are covered, except that:

A. Services received on an in-patient basis for the treatment of mental and nervous conditions will be payable only during a period in which benefits are payable under the Plan for room and board;

B. Out-patient services for the treatment of mental and nervous conditions, will be payable asset forth in the "Mental Health" segment.

(4) **Nursing Services:** Services of a nurse are covered provided such services at home are:

A. Prescribed by a physician; AND

B. Rendered by a registered professional nurse (R.N.); OR

C. Rendered by a licensed practical nurse (L.P.N.); AND

D. Not rendered by someone who lives in your home or by a member of your immediate family.

The following services are excluded; assistance with daily living, companionship or any other service that can be given by a less-skilled person, such as a home health aide. Please see the Home Health Care section of the SPD for limitations and exclusions. This benefit is limited up to 4 hours per day.

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

A. Licensed or certified to practice nurse-midwifery, AND

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

(6) **Manipulative Services:** services are not covered.

(7) **Podiatrists:** Services of duly licensed podiatrists for the treatment of:

A. Diseases

B. Injuries

C. Malformation of the foot

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

(8) **Hearing Aids:** Hearing aids, including the examinations for and the fitting of, are covered up to a total maximum reimbursement of $2,500, per ear, in any 36-month period. This includes the examination for and the fitting of hearing aids. Every two years for children under age 12. These benefits are not subject to the deductible or co-insurance. Repairs are not covered.

(9) **Durable Medical Equipment:** The rental, or purchase when appropriate, of durable medical equipment is covered if such equipment is customarily used for therapy and suitable for home use. Cochlear implants are covered as durable medical equipment. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. In the case of purchased equipment, coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

(10) **Prosthetics:** Artificial limbs or other prosthetic devices, including replacement when it is functionally necessary to do so, are covered.

(11) **Ambulance Service:** The following charges for ambulance services are covered medical expenses:

A. 100% of first $50 then 80% of eligible expense allowance for Ground or air Ambulance Transportation.

(12) **Cardiac Rehabilitation:** as deemed necessary as determined by Care Coordination.

(13) **Eye Care Following Cataract Surgery:** The following charges are covered.

A. One eye exam following cataract surgery.

B. One set of eyeglasses with intraocular (IOC) lenses, or

C. Multifocal intraocular (multifocal IOL) lens.

(14) **Voluntary Sterilization:** Charges for voluntary sterilization are covered medical expenses.

(15) **Miscellaneous Services:** The following services are covered under the major medical program portion of the Plan.

A. Diagnostic lab procedures and X-rays and X-ray or radiation treatments.

B. Oxygen and its administration.

C. Anesthetics and their administration, oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions.

D. Blood transfusions, including the cost of blood and blood products; however, such costs will be covered medical expenses only to the extent that there is evidence, satisfactory to the Plan, that such supplies could not be obtained without cost.

E. Chemotherapy

F. Dialysis and/or Hemodialysis. Non-Network benefits are not covered.

(16) **Professional Services For In-patient Psychiatric Care:** Services rendered by a physician for in- patient psychiatric care in a hospital are covered.

(17) **Pre-Donation Of Blood:** The cost to administer the pre-donation of blood prior to scheduled surgery will be a covered expense. A physician's statement will be required indicating that it was necessary, and the physician must state the quantity of blood to be donated.

(18) **Shoe or Foot Orthotics:** not to exceed $500.00 every three (3) years for adults and up to$250.00 once every year for children 12 and under.

(19) **Physical Therapists:** Services of a duly licensed physical therapist will be covered when those services are prescribed by a physician. The extent of coverage will be determined by the Plan based on an ongoing review.

(20) **Home Health Care Services and Supplies:** Charges for home health care services and supplies are covered only for care and treatment of an injury or sickness when hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, of up to four hours per day of services.

(21) **Hospice Care Services and Supplies:** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care services and supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered spouse and/or covered dependent children). Bereavement services must be furnished within one year after the patient's death.

(22) **Infertility:** In-Vitro fertilization and artificial insemination are covered up to a total of $25,000 lifetime maximum. Coverage includes diagnostic testing treatments and procedures. Individuals must contact Reproductive Resources to obtain these services. These services are provided at the in network level. Medication that is covered through pharmacy benefits are not subject to this maximum.

(23) **Injury to or care of mouth, teeth and gums:** Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under medical benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- No charge will be covered under medical benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(24) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a physician, result from an injury or sickness and improve a body function.

(25) **Organ transplant limits:** Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician and received at a Designated Facility.

Benefits are available for the evaluation for transplant, organ procurement and donor searches and transplantation procedures including the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/kidney transplants.
- Liver/intestinal transplants.
- Pancreas transplants.
- intestinal transplants.

If the organ or tissue donor is a covered person under the Plan, and the recipient is not, then the Plan will not provide coverage for expenses incurred by the donor.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

(26) **Reconstructive Surgery:** Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

(27) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a sickness that is other than a learning or mental disorder.

(28) **Surgical dressings, splints, casts** and other devices used in the reduction of fractures and dislocations.

(29) **Wig:** Charges associated with the initial purchase of a *wig after chemotherapy.*

(30) **Personal Health Support** - see Personal Health Support.

(31) **Virtual Visits**: Members have the ability to choose a virtual visit provider group, see and speak to a doctor using their mobile device or computer. During the virtual visit, members can obtain a diagnosis and a prescription that, if appropriate, can be sent to their pharmacy. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card. **Please Note**: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

(32) **Gender Dysphoria services:** Surgical and Non-Surgical Treatment of Gender Dysphoria is covered according to UnitedHealthcare's Gender Dysphoria standards.

(33) Telehealth Visits: Benefits are provided for services delivered via telehealth/telemedicine from network providers to the same extent as an in-person service under any applicable benefit category. Telehealth/Telemedicine is defined as live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

DEFINED TERMS

Active Employee is an Employee who is on the regular payroll of the employer and who has begun to perform the duties of his or her job with the employer on a full-time or part-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, or its equivalent, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator – United Healthcare (including its affiliates) which provides certain claim administration services for the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Congenital Heart Surgeries - corrective surgery to fix or treat a congenital heart defect.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms and that the Claims Administrator determines to be:

- Medically Necessary and are not specifically excluded in the Summary Plan Description;
- Included in the schedule of benefits and described in the benefit descriptions sections of this Summary Plan Description; and
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under the *General Information*, *Who is Eligible* section of this Summary Plan Description.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person is an employee, retiree or dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities that do not require continued administration by trained medical personnel in order to be delivered safely and effectively (even if the specific services are considered to be skilled services) and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-administered.

Dental Services – **Accidental Only** Dental services when treatment is necessary because of accidental damage and all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."

Dental services for final treatment to repair the damage must be both of the following:

- Started within 12 months of the accident, or if not a covered person at the time of the accident

then within 12 months of coverage under the Plan.

- Completed within 12 months of the accident, or if not a covered person at the time of the accident then within 12 months of coverage under the Plan.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Dependent – an individual who meets the eligibility requirements specified in the Plan. A Dependent does not include anyone who is also enrolled as an Employee.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health

Emergency Services. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

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

Employee means a person who is an active, regular employee of the employer, regularly scheduled to work for the employer in an employee/employer relationship or a retiree covered under the Plan. An independent contractor is not included in the definition of employee.

Employer is Suffolk School Employees Health Plan participating school districts.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Notwithstanding the above, an experimental or investigational service may be deemed to meet the

definition of a covered health service if such a service would be considered a covered service in a Medicare eligible program.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Family Unit is the covered employee or retiree and the family members who are covered as dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered employee's; the child depends on the covered employee for primary support; the child lives in the home of the covered employee; and the covered employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate hospital unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

Illness means a bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a plan participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a special enrollment period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

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

Maternity Services This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Medical Care Facility means a hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcare Online.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member –an eligible Employee of the Employer who is an active, regular employee of the employer, regularly scheduled to work for the employer in an employee/employer relationship or a retiree covered under the Plan. An independent contractor is not included in the definition of employee. Anyone who meets the District's eligibility requirements as per page 4.

Mental Health Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same

height, age and mobility as the covered person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Orthotics are devices, appliances, or braces that straighten or re-shape a body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Pharmacy means a licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Suffolk School Employees Health Plan, which is a benefits plan for certain employees of school districts participating in the SSEHP Plan and is described in this document.

Plan Administrator – Suffolk School Employees Health Plan.

Plan Participant is any employee, retiree or dependent who is covered under this Plan.

Plan Sponsor Suffolk School Employees Health Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Pregnancy is childbirth and conditions associated with pregnancy, including complications.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose monitors.

RAPL - Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

Retired Employee is a former active employee of the employer who was retired while employed by the employer under the formal written plan of the employer and elects to contribute to the Plan the contribution required from the retired employee's school district.

Sickness is a person's Illness, disease or pregnancy (including complications).

Skilled Care is skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from injury or sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, intellectual disabilities, custodial or educational care or care of mental disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialty Prescription Drug - Prescription Drug that is generally high cost, biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs through the Internet at **OptumRx.com** or by calling the number on the back of your ID card.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SSEHP is the Plan Sponsor.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a dependent child, the complete inability as a result of injury or sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Services Health Services for organ and tissue transplants.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

PLAN EXCLUSIONS

Note: All exclusions related to Medicare Part D can be found in your Evidence of Coverage Booklet from OptumRx.

This is not an all-inclusive listing. Please refer to other pertinent Sections in this document, when necessary.

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in the Glossary. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:

- Medically Necessary;
- described as a Covered Health Service in this Summary Plan Description; and
- not otherwise excluded in this Summary Plan Description.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Anesthesia.** Services or supplies for the administration of anesthesia, if the charges for surgery are not covered under this Plan.

(2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(3) **Cosmetic Surgery.** Cosmetic procedures except when considered reconstructive surgery.

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

Care is considered custodial when it is primarily for the purpose of meeting personal needs and

could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

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

(5) **Educational or vocational testing.** Services for educational or vocational testing or training.

(6) **Excess charges.** The part of an expense for care and treatment of an injury or sickness that is in excess of the Eligible charge.

(7) **Exercise programs and Equipment.** Exercise programs and equipment for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(8) **Experimental, Investigational or Unproven Services.** Services or supplies, including any hospitalization, in connection with such technology which is considered to be experimental, investigative, obsolete or ineffective in terms of generally accepted medical standards as determined by the Plan in its sole discretion with the advice of the Board of Trustees of the Suffolk School Employees Health Plan in appropriate cases. If a service is approved by Medicare it is considered a covered service.

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

A. not of proven benefit for the particular diagnosis or treatment of the covered person’s condition, OR

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

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

We may apply any or all of the following five criteria at our discretion in determining whether a technology is experimental, investigational, obsolete or ineffective:

a. Any medical device, drug or biological product must have received final approval to market by the US Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met.

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

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that, over time, the technology leads to improvement in health outcomes, i.e, the beneficial effects outweigh any harmful effects.

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

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

(9) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting.

(10) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions

(except open cutting operations for bunions only), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(11) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

(12) **Hospital employees.** Professional services billed by a physician or nurse who is an employee of hospital or skilled nursing facility and paid by the hospital or facility for the service.

(13) **Illegal drugs or medications.** Services, supplies, care or treatment to a covered person for injury or sickness resulting from that covered person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician. Expenses will be covered for injured covered persons other than the person using controlled substances and expenses will be covered for substance abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(14) **Legal actions or settlements.** Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you.

(15) **Medical summaries/invoice preparations.** Services rendered for medical summaries and medical invoice preparations.

(16) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(17) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(18) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a physician; or treatment, services or supplies when the covered person is not under the regular care of a physician, except for chiropractic services. Regular care means ongoing medical supervision or treatment, which is appropriate care for the injury or sickness.

(19) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(20) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness unless offered by UnitedHealthcare or its affiliates. Morbid Obesity unless deemed necessary, subject to review by Care Coordination.

(21) **Occupational.** Care and treatment of an injury or sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(22) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds, unless deemed medically necessary.

(23) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(24) **Relative giving services.** Professional services performed by a person who ordinarily resides in the covered person's home or is related to the covered person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(25) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.

(26) **Reversal of voluntary sterilization**. Reversal of voluntary sterilization and complications thereof.

(27) **Routine sonograms**. Routine sonograms solely to determine the gender of a fetus.

(28) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(29) **Sleep disorders.** Care and treatment for sleep disorders unless deemed necessary, subject to review by Care Coordination.

(30) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(31) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome. (Coverage for testing to determine diagnosis of TMJ is covered under the plan).

(32) **Travel or accommodations.** Charges for travel or accommodations, whether or notrecommended by a Physician, **except** as defined as a covered expense.

(33) **War.** Any **loss** that is due to a declared or undeclared act of war.

(34) **Cord Blood.**

Mental Health/Substance Use Disorder Exclusions

Exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

- services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder;
- educational/behavioral services that are focused on primarily building skills and capabilitiesin communication, social interaction and learning;
- tuition for or services that are school-based for children and adolescents under the *Individualswith Disabilities Education Act*;
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
- Transitional Living services.

□ Animal assisted therapies are excluded.

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Kidney Resource Services (KRS)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is

designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Regardless of whether you or a family member decides to participate in the KRS program, please be reminded that the Plan does not provide coverage for out of network dialysis/hemodialysis treatment.

Personal Health Support

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you
- are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications

needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

PRESCRIPTION DRUG BENEFIT
Prescription Drug Coverage is provided under OptumRx

	Network/Non-Network 30-Day Supply (up to 120 pills)	Network Only 90-Day Supply (up to 360 pills)
	Retail	Mail Order
Tier 1 drugs Copayment	$5.00	$10.00
Tier 2 drugs Copayment	$25.00	$37.50
Tier 3 drugs Copayment	$50.00	$75.00
Tier 4 drugs Copayment	$75.00	$112.50
	Supply Limit (Varies by Drug)	
Specialty Drugs Copayment	$10.00	

Generic First (Step Therapy Program)

Step Therapy Programs require the use of one or more Step One (Tier 1) medications (often a more affordable generic medication) that have been proven effective for most people with certain conditions before you can get a similar, more expensive, brand-name drug covered. This means that Step Two drugs (higher tiers) will not be covered under your drug benefit until Step One prescription drugs are first tried or your physician contacts OptumRx to obtain a prior authorization.

If you require a prior authorization for a Step Two drug, please call the Member Services Department at the telephone number listed on your OptumRx Rx member identification card.

If you already have an active prior authorization on file for a Step Two drug, or have tried a Step One drug, no action is needed.

Existing users (those having a history of receiving the medication) will not be required to conform to step therapy and will be grandfathered into the corresponding program.

Quantity Limits

Some drugs are subject to quantity limits. If the drug prescribed for you exceeds the recommended quantity limit, a message will be sent to your pharmacy indicating that the quantity limit has been exceeded. The prescription must be re-submitted according to the quantity limit guidelines or you may request your physician to be contacted to supply additional information regarding the quantity that is being requested.

Should you request that your physician be contacted, a fax will be sent to the prescribing physician requesting documentation of your diagnosis and other qualifying criteria. Once the physician completes and returns the form, a clinical pharmacist will review the information to determine whether the information meets the approval criteria. You, your physician and the pharmacy will be advised of the outcome.

Please note that the list of drugs that are subject to prior authorization or quantity limits may

change over time. If you want to check the list in the future, you may call OptumRx or visit our member web site. Members already registered with www.myoptumrx.com will be required to enter their user name and password.

New users will be required to create a user name and password. Please contact OptumRx at 877-633-4461 with any questions.

Prior Authorization

Certain drugs may require prior authorization before the prescription can be filled. If you are prescribed a medication that will be subject to the prior authorization process, request your physician to begin the prior authorization process as soon as possible. When you refill your medication on or after the first fill date, a message will be sent to the pharmacy stating that a prior authorization is required.

You or the pharmacy may advise your physician to contact OptumRx at 877-633-4461 to begin the Prior Authorization process or you may provide OptumRx with the physician's fax number and other appropriate information and OptumRx will contact the physician to begin the process.

For both Prior Authorization and Quantity Limits, you can check the list of drugs that are affected by the changes by calling OptumRx at 877-633-4461 or visit our member website at www.myoptumrx.com.

Enteral Formulas are covered under the Pharmacy Plan.

Copays are waived for diabetic supplies through your medical coverage.

Verification of Eligibility 877-633-4461 (actives and retirees under 65) or 855-253-3270 (Medicare retirees) through OptumRx Pharmacy Services.

Designated Pharmacy

If you require Specialty Prescription Drugs, OptumRx may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Specialty Prescription Drugs.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will apply for that Specialty Prescription Drug.

Refer to the tables at the beginning of this section for details on Specialty Prescription Drug supply limits.

Medicare Part D

Please refer to your Evidence of Coverage Booklet from OptumRx for complete details.

OptumRx Medicare Plan is the primary drug plan for all Medicare Primary members and their eligible spouses. This Plan is a Medicare Part D plan with expanded coverage designed specifically for SSEHP Medicare eligible retirees and their eligible dependents. You will only be responsible for the co-pays for each drug tier, regardless of the drug payment stage in the Medicare Part D plan.

If you are turning 65 call the Benefit Coordinator in your district 3 months prior to turning 65 in order to ensure a timely enrollment.

In addition, you may only have one Medicare Part D plan. If you have drug coverage through another plan and choose to opt-out of the SSEHP plan, you may still participate in the

medical portion of SSEHP. If you or your eligible spouse do not opt out of SSEHP, you may be dis enrolled from any other plan under which you have coverage. This may result in the loss of additional coverage from the other plan. Check all plans carefully before deciding.

If you do opt-out of the SSEHP Medicare Part D plan through OptumRx and later decide you want to again participate, there will be a 90 day waiting period to enroll.

Once eligible, you will receive a new ID card for the OptumRx Medicare Rx plan. Present this card to your pharmacist when filling a claim. Mail order service will be provided through OptumRx. Details of the plan and the mail order procedure will be sent to you upon enrollment.

Questions should be directed to Customer Service at 855-253-3270.

Pharmacy Drug Charge

SSEHP has entered into a contractual agreement with OptumRx Pharmacy Services for coverage of prescription medication both for retail pharmacies and mail order pharmacy provider.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Defined Terms.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy prescription is limited to a 30-day supply or 120 quantity, whichever is less. Any one mail order prescription is limited to a 90-day supply or 360 quantity, whichever is less.

Effective January 1, 2024, SSEHP will be changing the Specialty Drug member cost share.
As of January 1, 2024, the Plans Specialty drug copays will be changing to 50% with a maximum of $500 whichever is less.
Most of these medications have manufacturer assistance programs. These programs could lower your out-of-pocket expenses.
If your brand-name drug has a copay card available, there are a few ways to get one:
1. The fastest way is sign up on a manufacturer's website. Search for a medication or manufacturer website using your internet browser (Chrome, Edge, Safari, etc.) Example: Type in the drug name and "copay savings".
2. Ask your doctor or pharmacist about copay cards for your prescribed specialty drug(s).
3. You can also call OptumRx at, 1-855-427-4682. The Customer Service Team can assist you determining if your drug has a manufacturer copay coupon card associated with it and guide you t hrough the process.

When Coordinating Benefits with Another Plan

The prescription copayment amount is a covered charge under the Medical Plan for members whose Prescription Plans are primary to the Suffolk School Employees Health Plan Prescription Plan. Suffolk School Employees Health Plan members are then reimbursed at 100% of the copayment they paid with their primary insurance carrier. The following details the claim submission process:

Claim Submission Process:

Step 1. Member goes to the pharmacy and uses their primary carrier's health plan card.

Step 2. Member pays the primary carrier's copayment at the pharmacy and gets a receipt showing the amount paid.

*Step 3. Member fills out a United Healthcare claim form and attaches the pharmacy receipt.

Step 4. United Healthcare will process the claim and a check will be mailed to the member for full reimbursement.

*For accurate and expeditious claim processing, here are some helpful tips:

- Use one United Healthcare claim form per member.
- Only submit claims for dates of service within the calendar year.
- Please make sure that the pharmacy receipt is attached. Claims will not be processed without the receipt.
- Send Claims directly to:

United Healthcare Insurance Company LLC
P.O. Box 740827
Atlanta GA 30374-0827

Mail Order Drug Benefit Option

Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. These drugs are marked as **"maintenance" drugs** on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

To get order forms and information about filling your prescriptions by mail, please call the OptumRx Member Services or visit the website at: www.myOptumRx.com. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. However, if mail order is delayed, please call the OptumRx Member Services and an interim fill at your retail pharmacy can be arranged for you.

You must pay for your mail order prescription prior to your order being shipped. You can register a credit card and give permission to OptumRx to bill the credit card or you can enclose a check with your order. If your doctor submits a prescription electronically, it will not be filled until payment is made. Co-payment information is available on-line or by calling Customer Service. The Customer Service number is 877-633-4461for active members. Medicare Part D (EGWP) members should call 855-253-3270

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, infertility drugs, impotence medication and growth hormones, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies (not covered under the medical supply benefitor DME benefit) when prescribed by a physician.

Specialty Pharmacy Program

Call 1-877-633-4461 or 855-253-3270 for customer service.

NOTE: The use of Specialty Drugs is mandatory under the Plan.

Designated Pharmacy

If you require certain Prescription Drugs, OptumRx may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges. Use of the Specialty Drug Program is mandatory under the Plan.

Limits To This Benefit

This benefit applies only when a covered person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a physician.

(2) Refills up to one year from the date of order by a physician.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service under the *Schedule of Benefits* in this Section *Prescription Drug Benefit*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in this SPD under *Eligibility*.
- Not otherwise excluded in this Section *Prescription Drug Benefit* or under *Exclusions and Limitations* of this SPD.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance related and addictive disorders, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator’s sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance relatedand addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered prescription drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. These may be covered under the Durable Medical Equipment benefit.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the covered person unless prior authorization is received.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Immunization.** Immunization agents or biological sera. Please refer to medical benefits for coverage.

(9) **Injectable supplies (are covered under the pharmacy plan) or specialty medications.** A charge for hypodermic syringes and/or needles (other than for insulin) or specialty medications.

(10) **Inpatient medication.** A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(13) **No charge.** A charge for prescription drugs that may be properly received without charge under local, state or federal programs.

(14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(15) **Refills.** Any refill that is requested more than one year after the prescription was

written or any refill that is more than the number of refills ordered by the physician.

(16) **Health services and supplies that do not meet the definition of a Covered Health Service**. Covered Health Services are those health services including services, supplies, Prescription Drug Products, which UnitedHealthcare determines to be all of the following:

- Medically Necessary as defined in this Section *Prescription Drug Benefit*, under *Glossary – Outpatient Prescription Drugs*.
- Described as a Covered Health Service in this SPD under the Schedule of Benefits Prescription Drug Coverage Highlights in this Section *Prescription Drug Benefit*.
- Not otherwise excluded in this SPD.

HOW TO SUBMIT A MEDICAL CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator decides in its discretion that a Covered Person is entitled to them.

When a covered person has a claim to submit for payment that person must:

(1) Obtain a claim form from the Personnel Office, the Claims Administrator or www.ssehp.org.

(2) Complete the employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address*:

United Healthcare Insurance Company LLC
P.O. Box 740800
Atlanta GA 30374-0800

*Please refer to the Evidence of Coverage Booklet from OptumRx to submit a Medicare Prescription Drug claim.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator up to 90 days after the close of the Calendar Year. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time.

(b) The person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a plan participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the plan participant with a written notice of this denial. This written notice will be provided within 45 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a plan participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the plan participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 45-day period.

CLAIMS REVIEW AND APPEALS PROCEDURE

First Level Appeal

The First Level of Appeal is a claims review and is filed with UHC.

In cases where a claim for benefits payment is denied in whole or in part, the plan participant may appeal the denial. This appeal provision will allow the plan participant to:

(a) Request from the Claims Administrator a review of any claim for benefits. Such request must include: the name of the employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The participant should submit any data or comments to support the appeal, as well as any data or information requested by the Claims Administrator.

The request for review must be directed to the Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the plan participant with a written response within 60 days of the date the Claims Administrator receives the plan participant's written request for review. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the plan participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the plan participant's written request for review. Where possible, the review will be conducted by an employee of the Claims Administrator who did not previously review the claim. The appeal should be sent to:

UnitedHealthcare Insurance Company LLC
P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Second Level Appeals:

The second level of appeal is directly to the Plan. The member may address their appeal to:

United Healthcare Insurance Company LLC
ATTN: Suffolk School Employee Health Plan Appeals - SPOE Request
601 Brooker Creek Blvd
Oldsmar, FL 34677

This appeal should include a written explanation of the dispute and any supporting documentation, i.e. doctor's letter of medical necessity, and detail any extenuating circumstances. The appeal will be presented to the Appeals Committee of the Plan with all identifying information deleted. The Plan's Appeals Committee meets quarterly and presents appeals to the entire Board of Trustees. The determination of the Board of Trustees is final. The appellant will be notified of the Board's determination by the Claims Administrator.

The Claims Administrator's written response to the plan participant shall cite the specific Plan provision(s) upon which the denial is based.

Time Period for Final Level Appeals:

The final appeal must be filed within 180 days of the initial denial of the claim.

Urgent Situations Requiring Expedited Appeals:

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent requests for Benefits appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan.

If the appeal is denied, a further appeal to the Board of Trustees may be initiated by the participant and decided by the Appeals Committee and Chairperson of the Board of Trustees. Expedited appeal determinations will be made within 10 business days based upon the information available to the Appeals Committee and the Chairperson. The parties will be notified of the final determination by the Claim's Administrator.

Final Level of Appeal

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Suffolk School Employees Health Plan, or if Suffolk School Employees Health Plan fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Suffolk School Employees Health Plan's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Suffolk School Employees Health Plan's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization(IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making Suffolk School Employees Health Plan's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Suffolk School Employees Health Plan; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Suffolk School Employees Health Plan The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Suffolk School Employees Health Plan's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individualor would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile

or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review 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. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Filing a Suit for Benefits:

A plan participant must exhaust the claims appeal procedure before filing a suit for benefits.

Lawsuits to obtain benefits may not be commenced more than two (2) years following the date of denial of benefits.

For information regarding the appeals process for Medicare Part D Prescription Drugs, please refer to Chapter 7 in the Evidence of Coverage Booklet from OptumRx.

COORDINATION OF BENEFITS

If a covered person is entitled to benefits for medical care and/or prescription drug benefits under this Plan and at least one other plan, the amount of benefits provided by this Plan for that care, if this Plan is the Secondary Plan, may be reduced to the extent that the total benefits paid or provided by all plans are not more than the total of the allowable expenses that the person incurs. As each claim is submitted, the Secondary Plan determines its obligations to pay for the stated percentage of allowable expenses based on the expenses included in that claim.

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

"Plan" may include:

1) any group insurance, or any other method of coverage for persons in a group.

2) an uninsured arrangement of group coverage.

3) group coverage through HMOs and other prepayment, group practice and individual practice plans.

4) any governmental plan, but not including a state plan under Medicaid.

5) any plan required by law, but shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

6) the medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

"Plan" shall NOT include:

1) blanket school accident coverage; or

2) hospital indemnity coverage.

"This Plan": This term means that part of this Plan that provides benefits for medical care.

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

(1) the plan does not have a Coordination of Benefits provision like this Plan; **OR**

(2) the plan, in accord with Order of Payment, would determine its benefits first.

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

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

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

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

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

"Order of Payment for Non-Medicare Members": When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

(1) A plan, which does not have a provision like this Coordination of Benefits, will pay before this Plan.

(2) A plan, which covers a person other than as a dependent, will pay before a plan that covers a person as a dependent.

(3) A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year; provided that:

(a) If said dates of birth are the same, the plan that has covered a person for the longest time will pay first.

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

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

(a) first, the plan of the parent with custody of the child;

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

(c) finally, the plan of the parent not having custody of the child.

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

(4) The benefits of a plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a plan which covers such person as a laid-off or retired employee or a person covered under another plan as an active employee.

(5) If the above four rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first. The length of time a person has been covered under a plan is determined by the following:

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

(b) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

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

(1) To give or to get any data needed to determine benefits under this provision; and each person claiming benefits under a plan must give the Coordinator any data needed to pay the claim.

(2) To pay an organization for the payment made under its plan, which should have been paid by the Coordinator. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan. The term **"payment made"** includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(3) To recover any excess if the amount paid is more than it should have paid under this provision from one or more of:

(a) the persons it has paid or for whom it has paid;

(b) insurance companies; or

(c) other organizations.

Co-pays as secondary or tertiary carrier to prime insurance or Medicare, UHC is to reimburse the co-pay in full to member/provider.

COORDINATING YOUR SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN BENEFITS WITH MEDICARE

MEDICARE: A FEDERAL PROGRAM:

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

Medicare has three medical parts: **Part A (Hospital insurance)** which can help pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care; **Part B (medical insurance)** which can help pay for necessary physicians' services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare; and **Medicare Advantage Part C,** if you have Medicare Parts A and B, you can join a Medicare Advantage (formerly Medicare + Choice) plan.

PRIMARY COVERAGE:

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

If you, your spouse or other dependents become eligible to receive primary Medicare benefits under the Federal program, you or your covered dependents MUST enroll in Medicare. **If you do not, your benefits under the Suffolk School Employees Health Plan will be drastically reduced.**

WHEN THE SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN PAYS FIRST:

The Suffolk School Employees Health Plan will automatically provide primary coverage for an Active Employee, regardless of age, and for the Employee's enrolled Dependents. For those who are eligible for Medicare due to permanent kidney failure, the Suffolk School Employees Health Plan is primary for generally the first 30 months of treatment, then Medicare becomes primary.

The Suffolk School Employees Health Plan also will automatically provide primary coverage for eligible retired Employees, their Spouses, and other enrolled eligible Dependents who are under age 65 and are not disabled.

WHEN MEDICARE PAYS FIRST:

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

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

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

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

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

ENROLLING IN MEDICARE:

As An ACTIVE Employee Age 65 or Over: Since the Suffolk School Employees Health Plan automatically provides primary coverage for you and your enrolled dependents, you may delay enrollment in Medicare Parts A and B without penalty until you retire. Or, you may enroll at 65, but delay activating your benefits until you retire and need the coverage.

When you enroll in Medicare, you may elect it as your primary group insurer by notifying your District's Benefits Administrator in writing. **However, if you do choose Medicare as your primary coverage while you are still an Active Employee, Suffolk School Employees Health Plan coverage for you and your enrolled eligible Dependents will end, and your benefits will be drastically reduced.**

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

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

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

How to Enroll: You can sign up for Medicare by telephone, mail, or in person. Contact your local Social Security Office.

Note: Not enrolling could reduce your benefits drastically.

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

Suffolk School Employees Health Plan Supplements Medicare: After you retire, the Suffolk School Employees Health Plan will not provide any benefits that could be obtained from Medicare, but it will provide benefits to supplement those available from Medicare.

You will continue to have the same benefits available under the Suffolk School Employees Health Plan as you had before you were eligible to receive **any** Medicare benefits.

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

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Medicare Premium Reimbursement:

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

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

Since reimbursement practices vary from district to district, you should contact your District's Benefits Administrator for information. Documentation of paid premiums are required for reimbursement

Extra charges imposed by Social Security as penalties for late enrollment in Medicare are not reimbursable under the Suffolk School Employees Health Plan.

FILING CLAIMS UNDER MEDICARE AND THE SUFFOLK SCHOOL EMPLOYEES HEALTH PLAN:

Expenses covered by Medicare must be submitted to Medicare before being submitted to the Suffolk School Employees Health Plan when Medicare is the primary carrier.

Inpatient Hospital Expenses: When you are admitted to a hospital, you must show both your Suffolk School Employees Health Plan Hospitalization and Medicare cards to the admitting office. You should not be billed for any charges covered under these programs.

The hospitalization portion of the Suffolk School Employees Health Plan will pay the initial Medicare deductible, the Medicare co-insurance 61st - 90th day, and the full amount of necessary charges from the 91st day.

If you exhaust the Hospitalization benefits and your Medicare 60-day reserve, themajor medical portion of the Suffolk School Employees Health Plan will provide benefits for additional covered inpatient charges.

Outpatient Hospital Expenses: Necessary outpatient hospital expenses incurred for surgery, emergency illnesses, emergency accident cases, diagnostic X-rays and laboratory tests which are not covered by Medicare will be covered by the hospitalization portion of the Suffolk School Employees Health Plan subject to a copayment with certain limitation described in the hospitalization section of this booklet. Outpatient charges should be submitted by the hospital with the Medicare Explanation of Benefits form (EOB) and an itemized bill to:

United Healthcare Insurance Company LLC
P.O. Box 740800
Atlanta GA 30374-0800

Network Provider Program and Major Medical Coverage: Whether you receive services from a Suffolk School Employees Health Plan Network Provider or from a provider who does not participate in the Suffolk School Employees Health Plan, you should discuss payment before you receive services. If your provider does not accept Medicare assignment, you may be required to pay the Medicare reimbursable amount at the time of service.

If the provider participates in the Suffolk School Employees Health Plan, you are responsible for paying a copayment to the provider. An example would be the copayment for a Physician's office visit. But the amount you owe may be less, depending on how much Medicare reimburses.

CLAIMS DEADLINE:

If you are not enrolled in Medicare Crossover, Suffolk School Employees Health Plan claims must be submitted no later than 90 days after the end of the Calendar Year or 90 days after you receive your Medicare EOB, **whichever is later.**

When You Reside Outside the United States: Medicare does not cover medical expenses incurred outside the United States. The Suffolk School Employees Health Plan pays as primary insurer, whether or not you are enrolled in Medicare. Part B reimbursement from your former employer will be discontinued. You must notify your former employer (in writing) if you will be residing outside the United States.

When you know that you will be residing outside the United States, you must notify your former employer, in writing, and your Social Security office. Social Security will send you a

form that you must sign and return, indicating your desire to continue Medicare coverage when you return.

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

RE-EMPLOYMENT:

If you return to work with an employer who participates in the Suffolk School Employees Health Plan and meet the eligibility requirements for coverage, the Suffolk School Employees Health Plan will again provide primary coverage for you and your enrolled dependents.

At the time of your re-employment, contact your District's Health Benefits Administrator to arrange to notify United Healthcare and to find out your effective date for Suffolk School Employees Health Plan coverage.

MISCELLANEOUS PROVISIONS

CONFINED ON DATE OF CHANGE OF OPTIONS OR COVERAGE:

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

(1) if the transfer is out of the Plan, and you are confined on the day coverage ends, the Suffolk School Employees Health Plan will be responsible for the inpatient hospital claim only; and

(2) if the transfer is into the Plan, benefits are payable to the extent they are not paid through the former health insurance program.

TERMINATION OF COVERAGE:

(1) Coverage will end at the end of the month in which you are no longer eligible to participate in this Plan. Refer to the General Information section.

(2) If this Plan ends, your coverage will end.

(3) Coverage for a dependent will end on the date that dependent ceases to be a dependent as defined in the General Information section.

REFUND TO THE PLAN FOR OVERPAYMENT OF BENEFITS

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legallyhave to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly

refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

Defined terms:

"Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the covered person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, punitive damages, lost wages and any other recovery of any form of damages or compensation whatsoever. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan’s subrogation and reimbursement rights.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the injury or sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the covered person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

When this provision applies. The covered person may incur medical or dental charges due to Injuries that may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the covered person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the covered person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim that the covered person has against any third party, or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the covered person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to Subrogation or Refund. The covered person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all recoveries and funds paid by a third party to a covered person relative to the injury or sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the covered person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the covered person's third party claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the

rights assigned to it, are limited to the extent to which the Plan has made, or will make,

payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical expenses from the covered person. Also, the Plan's right to Subrogation still applies if the recovery received by the covered person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the covered person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the covered person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a covered person if a covered person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the covered person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or sickness caused by a responsible third party until after the covered person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all recoveries, as well as approval for the execution of any papers necessary forthe enforcement thereof, as described herein.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan (which will be treated as third party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan as well as those that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount ofthe overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details anyoutstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss anyoutstanding balance owed to the Plan.

Rights of Claims Administrator. The Claims Administrator has a right to request reports on and approve of all settlements.

Interpretation of Benefits

Suffolk School Employees Health Plan and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

■ Interpret Benefits under the Plan.
■ Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
■ Make factual determinations related to the Plan and its Benefits.

Suffolk School Employees Health Plan and UnitedHealthcare may delegate this discretionary authority to other persons or entities including UnitedHealthcare's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and UnitedHealthcare's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Suffolk School Employees Health Plan may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Suffolk School Employees Health Plan does so in any particular case shall not in any way be deemed to require Suffolk School Employees Health Plan to do so in other similar cases.

RESPONSIBILITIES FOR CLAIMS ADMINISTRATION

CLAIMS ADMINISTRATOR. Suffolk School Employees Health Plan is the benefit plan of Suffolk School Employees Health Plan, the Plan Sponsor. United Healthcare is the third party administrator of the Plan and serves as the Claims Administrator at the convenience of the Plan.

The Plan Sponsor and Claims Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Claims Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a plan participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Sponsor will be final and binding on all interested parties.

DUTIES OF THE PLAN SPONSOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a plan participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims and administer the Plan.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the employer and contributions made by the covered employees and retirees.

The level of a participant's contributions will be set by the School District. These participant contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

Benefits are paid directly from the Plan through the Claims Administrator.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Sponsor or Claims Administrator or an agent of either in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to 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 it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Suffolk School Employees Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 11-3085143

PLAN EFFECTIVE DATE: January 1, 1992

RESTATEMENT DATE: June, 2017

PLAN YEAR ENDS: December 31st

PLAN SPONSOR

The Board of Trustees of the Suffolk School Employees Health Plan
Suffolk School Employees Health Plan
c/o Eastern Suffolk BOCES
201 Sunrise Highway
Patchogue, New York 11772

CLAIMS ADMINISTRATOR

United Healthcare Insurance Company
9900 Bren Road East
Minnetonka, MN 55343

BOARD OF TRUSTEE(S)

Executive Director, Chairperson
Ms. Sheila MacFadyen

Assistant to the Executive Director
Mr. Richard Forzano

Founder and Special Advisor to the Plan
Mr. Richard Seidell

Employee Member Trustees
Mr. Richard Forzano - Smithtown Central School District
Jean Gray - South Country Central School District
Ms. Sheila MacFadyen - Three Village Central School District

Managerial Member Trustees
Mr. Andrew Tobin- Smithtown Central School District
Jennifer Tangui - South Country Central School District
Mr. Jeffrey Carlson - Three Village Central School District

BY THIS AGREEMENT, Suffolk School Employees Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Suffolk School Employees Health Plan on or as of the day and year first below written.

By 

Use and Disclosure of Protected Health Information

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

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

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

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximum and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amount due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payment;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Care Coordination.
- Reimbursement plan.

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

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
- management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
- customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

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

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

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

C. Adoption of Third Party Administrator and Pharmacy Benefits Manager HIPAA Privacy Policies and Procedures

The Plan adopts the policies and procedures of their Third Party Administrator and Pharmacy Benefits Manager, with respect to all HIPAA privacy requirements for the use and disclosure of PHI and Individual rights with respect to PHI including but not limited to:

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

D. For Purposes of This Section The Board of Trustees of the Suffolk School Employees Health Plan Is the Plan Sponsor

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

ATTACHMENT

Nondiscrimination and Accessibility Requirements

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator

UnitedHealthcare Service LLC Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

Your can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

For individuals with limited English proficiency

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

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Appendix:

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described under Eligible Expenses in this section. As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount UnitedHealthcare determines to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under Eligible Expenses as described under Eligible Expenses in this section. As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount UnitedHealthcare determines to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

- Out-of-network providers may not balance bill covered persons for ancillary services received at certain network facilities or non-ancillary services provided without proper notice and consent, out-of-network air ambulance transport and out-of-network emergency health care services.
  The eligible expense for covered health services received from out-of-network providers for ancillary services received at certain network facilities or non-ancillary services provided without proper notice and consent, out-of-network air ambulance transport and out-of-network emergency health care services is based upon: reimbursement rate determined by applicable state law or all payor model agreement, the initial payment made or the amount subsequently agreed to by the out-of-network provider or the amount determined by independent dispute resolution (IDR).