Catastrophe Major Medical Plan
Plan Document

Policy # CMMI - 003

Sponsored by:
Board of Trustees of the New York State United Teachers (NYSUT) Member Benefits Catastrophe Major Medical Insurance Trust

Voluntary CMM Plan
Amended and restated effective January 1, 2023
Originally effective January 1, 2018

PLAN SPONSOR EMPLOYER IDENTIFICATION NUMBER (EIN):
47-7358956

TRUSTEES

J. Philippe Abraham, Chairperson
Michele Bushey
Sandra Carner-Shafran
Laura Franz
Roderick P. Sherman
Mike Sill

The Trustees' business address is NYSUT Member Benefits Catastrophe Major Medical Insurance Trust, 800 Troy-Schenectady Road, Latham, NY 12110-2455.

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Special Notice to Participants

Effective March 30, 2021, and retroactively effective to March 1, 2020, and continuing through the end of the COVID-19 "outbreak period" (defined as March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency), the Plan provides the following relief to Plan Participants and Beneficiaries:

The applicable deadlines for the exercise of any of the Participant/Beneficiary rights described below that fall during the COVID-19 "outbreak period" (March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency) will be suspended until the earlier of: (1) one year following the date of the original deadline; or (2) the end of the COVID-19 "outbreak period." For the avoidance of doubt, this Special Notice also covers the periods and dates below, if applicable, for Policy CMMI-001, previously incorporated by reference in the Plan Document.

1) The 60-day deadline for electing COBRA continuation coverage after experiencing a COBRA qualifying event.

2) The initial 45-day COBRA premium payment deadline and the subsequent 30-day COBRA premium payment deadlines.

3) The deadlines for individuals to notify the Plan of a qualifying event (60-days after the qualifying event) or determination of disability.

4) The five-year deadline under Policy CMMI-001 and the two-year deadline under Policy CMMI-003 for filing a benefit claim under the Plan's claims procedure.

5) The deadline to file first and second level appeals of Adverse Benefits Determinations under the Plan's appeals procedures (180-days following the date on the EOB for a first level appeal and 60-days following receipt of the first level appeal decision for a second level appeal).

6) The four-month deadline to file a request for external review, if available, after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

7) The deadline to file information to perfect a request for external review, if available, upon a finding that the request was not complete (the later of expiration of the four month filing period or 48-hours following a claimant's receipt of notification of a deficient request for external review).

8) The 60-day deadline to request enrollment of a newly-acquired spouse or dependent child(ren) following the marriage, birth, adoption, or placement for adoption.

9) The 60-day deadline to select coverage continuation options under the Plan (other than COBRA) after the Participant's NYSUT Membership lapses, the Participant dies, the Participant divorces/legally separates, or a covered child attains age 30.

Where the relevant deadline, as adjusted above, falls between March 1, 2021 and June 30, 2021, the Plan will grant a grace period until July 1, 2021.

The Plan may also disregard the above-specified period when determining the date for the Plan to provide a COBRA election notice.

COVERAGE OF COVID-19 TESTING, INCLUDING OTC TEST KITS, DURING THE FEDERALLY DECLARED EMERGENCY PERIOD

The Plan reimburses your out-of-pocket costs for products for the diagnosis of COVID-19 that are approved, cleared, or authorized by the FDA, and the administration of such products with no limit for tests ordered or administered by a health care provider following an individual clinical assessment. These products include, as of January 15, 2022, and without the requirement of a physician's order, up to eight (8) at-home COVID-19 OTC Tests per covered participant per month. **These tests will be covered as preventive services with no cost-sharing following the submission and processing of claims for such services and items by your Basic Plan(s) through the end of the federally declared emergency.**

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I. INTRODUCTION: WHAT THIS DOCUMENT TELLS YOU

This Plan Document describes the Catastrophe Major Medical benefits as provided by the Catastrophe Major Medical Plan (the "Plan") sponsored by the Board of Trustees of the New York State United Teachers Member Benefits Catastrophe Major Medical Insurance Trust (the "Trust"). **This coverage is supplemental to your basic health coverage**. This Plan Document was revised effective January 1, 2023, for claims incurred on or after such date, and replaces all other plan documents, amendments, certificates and applicable riders to those documents previously provided to participants. Please note that for Benefit Period effective dates on or before December 31, 2013, the previous certificate of insurance applies, for Benefit Period effective dates between January 1, 2014 and December 31, 2017, policy CMMI-001 applies, and for Benefit Period effective dates between January 1, 2018 and December 31, 2022, policy CMMI-003 effective January 1, 2018 applies.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility section in this document. This is voluntary coverage for which you must enroll. Coverage is conditioned on you properly having enrolled yourself and any eligible dependents and providing proof of dependent status satisfactory to the Plan, as well as paying the premiums in a timely manner.
- The person named, and their covered dependents, if applicable, on the "Schedule of Benefits" are covered for the benefits described in this Plan Document. This coverage is subject to the eligibility and effective date requirements of the Plan. The effective date of your coverage is listed on the Schedule of Benefits.

This document will help you understand and use the benefits provided by the Plan. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverage provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information.

The Plan Sponsor of this Plan is the Trust. The benefits of the Plan are self-insured with contributions (referred to in this document as "premiums") from eligible participants held in a trust and used to pay Plan benefits. Premiums to the Plan are pooled for the purposes of determining premium rates and accounting. The Trust may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the Plan as determined appropriate by the Trustees.

While the Board of Trustees is the Plan Administrator and "Named Fiduciary" for purposes of ERISA, the Board has designated Ginger B. LaChapelle as the Plan Administrator responsible for carrying out the Trustees' decisions and for overseeing the daily operation of the Plan and the Fund Office.

The Trust has entered into an agreement with an Administrator, Association Member Benefits Advisors (AMBA), responsible for enrollment, eligibility, customer service and premium collection, as well as claims processing and coordination of appeals for Benefit Period effective dates prior to January 1, 2018. The Trust has entered into an agreement with another Administrator, HealthSmart Benefit Solutions, Inc., for claims processing, coordination of appeals and customer service for Benefit Period effective dates on or after January 1, 2018.

IMPORTANT INFORMATION

The Trust is committed to maintaining this coverage for participants and their families at an affordable cost; however, because future conditions cannot be predicted, the Trust reserves the right to amend or terminate the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Rates change based on the Plan's experience and are typically effective each July 1, although the Trust may elect not to change rates on a July 1 or may elect to change rates more frequently.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

IMPORTANT REMINDER

All participants must be covered by or insured under a Basic Plan, as defined in the *Definitions* section.

You or your dependents must promptly furnish to the Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in domestic partnership status, or change in status of a dependent child.

Notify the Administrator within 60 days, after any of the above noted events. Failure to give the Administrator a timely notice (as noted above) may cause your spouse and/or your covered family members to lose their ability to obtain COBRA Continuation Coverage; may cause the coverage of a dependent child to end when it otherwise might continue because of a disability; may cause claims to not be able to be considered for payment until eligibility issues have been resolved; or may result in a participant's liability to repay the Plan if any benefits are paid to an ineligible person.

QUICK REFERENCE CHART	
Plan Sponsor and ERISA Plan Administrator	Board of Trustees of the NYSUT Member Benefits Catastrophe Major Medical Insurance Trust 800 Troy-Schenectady Road Latham, NY 12110-2455 Phone: (800) 626-8101 Website: memberbenefits.nysut.org
Plan Administrator	Ginger B. LaChapelle NYSUT Member Benefits Catastrophe Major Medical Insurance Trust 800 Troy-Schenectady Road Latham, NY 12110-2455 Phone: (800) 626-8101 Website: memberbenefits.nysut.org
Administrator **Responsible for:** ➢ Enrollment/Eligibility ➢ Customer service ➢ Premium collection ➢ Claims processing and coordinating appeals for Benefit Period effective dates prior to January 1, 2018	Association Member Benefits Advisors (AMBA) P.O. Box 9186 Des Moines, IA 50306-9186 Phone: (888) 386-9788 Website: nysutmbteinsurance.com
Administrator **Responsible for:** ➢ Customer service ➢ Claims processing and coordinating appeals for Benefit Period effective dates on or after January 1, 2018	HealthSmart Benefit Solutions, Inc. P.O. Box 1014 Charleston, WV 25324-1014 (844) 552-7805 Website: healthsmart.com/nysut

II. SUMMARY OF BENEFITS

Overview of Deductibles, Coinsurance, Out-of-Pocket Maximum and Maximum Plan Benefits		
	In-Network	**Out-of-Network**
Preventive Benefits	$0 coinsurance No Deductible	$0 coinsurance No Deductible
Critical Illness Benefit	$0 coinsurance No Deductible	$0 coinsurance No Deductible
Overall Annual Out-of-Pocket Deductible The amount you owe each calendar year before the Plan will begin to reimburse you for Covered Charges. The amount applied to the Deductible is the lesser of paid charges or the amount considered to be allowed under this Plan. Note: This overall Deductible is not required in order to access the convalescent/custodial care, Nursing Home, Assisted Living Facility and home health care benefits (see specific sections for details).	$2,000/Individual $4,000/Family	$5,000/Individual
Reimbursement Amount How the Plan will reimburse you for out-of-pocket covered medical expenses, after the Deductible is met.	Except as otherwise described in this Summary of Benefits, the Plan generally reimburses 100% of the Covered Charge (less payment made by Basic Plan)	Generally, the Plan reimburses 70% of the Covered Charge (less payment made by Basic Plan)
Benefit Period	Calendar Year (12 months)	

	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum for In-Network Benefits for Essential Health Benefits The maximum amount you are responsible for paying for In-Network expenses for Essential Health Benefits each calendar year before the Plan reimburses 100% of your covered In-Network eligible out-of-pocket medical expenses under your Basic Plan.	$2,000/Individual $4,000/Family	Not Applicable
Charges for • **Inpatient services** • **Physician Services** • **Physiotherapy** • **Outpatient and Professional Services** • **Durable Medical Equipment and Medical Supplies** • **Ambulance Services**	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan)	Plan reimburses 70% of the Covered Charge (less payment made by Basic Plan)
Charges for Emergency Services in a Hospital Emergency Department	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan)	
Charges for Prescription Drugs	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan)	Plan reimburses 70% of the Covered Charge (less payment made by the Basic Plan)
Charges for Skilled Nursing Services In a Skilled Nursing Facility or Subacute Care Facility for active and progressive treatment Limited to lifetime maximum of 100 days while eligible for benefits under the Plan.	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit	Plan reimburses 70% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit
Charges for Private Duty Nursing • Up to $15 per hour ($360 per day) • Limited to a lifetime maximum of $35,000 while eligible for benefits under the Plan	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit	Plan reimburses 70% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit

	In-Network	Out-of-Network
Charges for Home Health Care • Up to 25 hours per calendar week • Limited to a maximum of 6,000 hours per lifetime while eligible for benefits under the Plan • Benefits begin following 60 hours of paid home health care per calendar year	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit An In-Network provider is a Home Health Care Agency that is Medicare-certified or licensed or certified by a state regulatory authority responsible for licensing or certifying Home Health Care Agencies	Plan reimburses 30% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit An Out-of-Network provider is one that is not a Home Health Care Agency certified by Medicare or licensed or certified by a state regulatory authority responsible for licensing or certifying Home Health Care Agencies
Charges for convalescent/custodial care in a Convalescent Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility • Up to $72 per day • Limited to a maximum of $80,000 per lifetime while eligible for benefits under the Plan • Benefits begin on the 20th day of confinement	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit An In-Network facility is a Medicare-certified facility or, in the case of an Assisted Living Facility, one that is licensed to operate under the laws of the state in which it is located	No benefits for an Out-of-Network facility An Out-of-Network facility is one that is not a Medicare-certified facility or, in the case of an Assisted Living Facility, one that is not licensed to operate under the laws of the state in which it is located
Charges for Hospice care • Up to 210 consecutive days of confinement per lifetime while eligible for benefits under the Plan • Up to five (5) visits for bereavement counseling for family per lifetime	Plan reimburses 100% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit	Plan reimburses 70% of the Covered Charge (less payment made by Basic Plan) up to the maximum benefit

Please note: See the *Benefits, Exclusions and Limitations* section for details regarding the above benefits.

III. ELIGIBILITY: HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

ELIGIBLE CLASSES OF PARTICIPANTS INCLUDE:

1. All eligible NYSUT Members (as defined in the *Definitions* section) who were covered under the Prior Plans on December 31, 2017, as well as their dependents who were covered under the Prior Plans as of December 31, 2017;
2. As of January 1, 2018, new dependents of NYSUT Members who were covered under the Prior Plan on December 31, 2017 who qualify for coverage;
3. As of January 1, 2018, NYSUT Members who meet the following requirements at the time of enrollment:
   a. Currently Employed in a position where you are represented for purposes of collective bargaining by a NYSUT affiliate;
   b. Residing in New York State; and
   c. Enrolled in the Plan during an open enrollment period;
4. As of January 1, 2018, eligible dependents of NYSUT Members first covered on or after January 1, 2018. The dependents must have been enrolled in the Plan along with the NYSUT Member during the open enrollment period or be new dependents who qualify for coverage; and
5. As of January 1, 2023, NYSUT Members who meet the following requirements at the time of enrollment:
   a. Currently Employed in a position where you are represented for purposes of collective bargaining by a NYSUT affiliate; and
   b. Enrolled in the Plan during an open enrollment period.

All eligible participants must be a NYSUT Member or be an eligible dependent of a covered NYSUT Member <u>and</u> be covered by or insured under a Basic Plan (as defined in the *Definitions* section).

BASIC PLAN REQUIREMENT

All eligible NYSUT Members who were covered under the Prior Plans on December 31, 2017, as well as their dependents who were covered under the Prior Plans as of December 31, 2017, must be covered by a Basic Plan as that term was defined under the Prior Plans on December 31, 2017. This definition appears in Section VII – *Definitions*.

As of January 1, 2018, eligible NYSUT Members who were not covered under the Prior Plans on December 31, 2017, as well as their eligible dependents who were not covered under the Prior Plans on December 31, 2017, must be covered by a Basic Plan as that term is defined under this Plan. This definition appears in Section VII – *Definitions*.

As of January 1, 2018, eligible new dependents of NYSUT Members must be covered by a Basic Plan as that term is defined under this Plan. This definition appears in Section VII – *Definitions*.

Dependents must be covered under the same Basic Plan as the Member or another Basic Plan as defined above.

No benefits will be payable if a covered individual does not maintain coverage under a Basic Plan. The Plan reimburses a percentage of your out-of-pocket costs under your Basic Plan. This coverage is supplemental to your basic health coverage.

DEPENDENT ELIGIBILITY

If you elect or are enrolled in coverage for yourself, your eligible dependents are also eligible for coverage on the later of the day you become eligible for your own coverage or the day you acquire an eligible dependent either by marriage, birth, adoption or placement for adoption. You must submit a completed written enrollment form (as described in the *Enrollment Procedures* subsection of this section) and provide the Plan's required proof of dependent status and pay any required premium.

Eligible Dependents who may be enrolled in the Plan include:

1. Lawful spouse; or
   Domestic partner

   For the purposes of the Plan, references to "spouse" will read "domestic partner" as it applies, unless specifically stated otherwise.

2. Children who are:
   a. under age 30; or
   b. an unmarried child over age 29 and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the mental or physical disability must be sent to the Administrator within 31 days after the child attains the age limit.

   "Children" include natural children, stepchildren, adopted children and foster children. Adopted children include a child placed for adoption from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the Hospital prior to the finalization of the child's adoption. Placed for adoption means the assumption and retention by the participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.

   Qualified Medical Child Support Orders - According to federal law, you might be requested to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state agency that usually results from a divorce or legal separation. The Administrator can provide more details about enrolling your children in such cases. The Administrator will notify the NYSUT Member if a QMCSO is received. You may obtain a copy of the Plan's QMCSO procedures free of charge by contacting the Administrator.

Please note:
- A person who is not covered under a Basic Plan is not considered an eligible dependent.
- A person (other than a Child under the age of 30) who is in the military service is not considered an eligible dependent.
- Covered participants' parents and/or parents-in-law are not considered eligible dependents. However, parents and/or parents-in-law of covered participants who were enrolled in the Prior Plan may maintain their coverage.
- A person who is covered as a NYSUT Member cannot be covered as a dependent.
- If both the covered NYSUT Member and their spouse are covered under the Plan as covered NYSUT Members, their children may be covered as eligible dependents of either, but not both.

ENROLLMENT PROCEDURES

This is voluntary coverage for which you must enroll yourself and your eligible dependents and pay the necessary premiums.

OPEN ENROLLMENT

Open enrollment is a period of time determined by the Plan Administrator during which eligible NYSUT Members may enroll and/or enroll their eligible dependents. Keep in mind that no dependent may be covered unless you are covered.

The Plan Administrator will provide information about the open enrollment period in advance and provide you with instructions on how to complete the process. All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the open enrollment period to the Plan Administrator or its designee along with proof of dependent status (as required).

If you do not enroll yourself, or if you do not enroll eligible dependents, during the open enrollment period, you will not be able to enroll yourself and/or them until the next open enrollment period.

ENROLLMENT OF NEW DEPENDENTS

If you are enrolled for coverage under this Plan and acquire a spouse by marriage, or acquire any dependent child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new spouse and/or any dependent child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)

DEPENDENT ENROLLMENT PROCEDURES AND PROOF OF DEPENDENT STATUS

Enrollment must be requested from the Administrator within 60 days after the Life Event. In addition, you must submit to the Administrator a completed Change Form and proof of dependent status (as applicable), as well as pay the required premium.

If you do not enroll within the above timeframe, you will not be able to enroll your dependent(s).
Proof of dependent status includes a copy of the following:

- **Spouse/Marriage:** Marriage certificate.
- **Child/Birth:** Birth certificate showing biological child of the covered NYSUT Member.
- **Stepchild:** Birth certificate or adoption papers and marriage certificate.
- **Adoption or placement for adoption:** Court order signed by the judge showing that the covered NYSUT Member has adopted or intends to adopt the child and certified birth certificate.
- **Foster Child:** Court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate and proof of any state-provided health coverage.

- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and depends chiefly on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner:** Signed affidavit by the covered NYSUT Member and domestic partner and proof that they meet the requirements of the Plan's domestic partner eligibility.

START OF COVERAGE FOLLOWING ENROLLMENT OF NEW DEPENDENT

- **Coverage of a new spouse or domestic partner** who is properly enrolled, as described above, will become effective as of the first of the month after the Administrator receives your properly completed paperwork and premium payment.
- **Coverage of a newborn or newly adopted newborn dependent child** who is properly enrolled, as described above, will become effective as of the date of the child's birth. Note that each newborn child who becomes a dependent child will be covered under the Plan for 31 days from the date of birth.
- **Coverage of a newly adopted dependent child or dependent child placed for adoption** who is properly enrolled, as described above, more than 60 days after birth, but within 60 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

TERMINATION OF COVERAGE

Date coverage ends for covered NYSUT Member

Your (the covered NYSUT Member's) coverage will end at the earliest of:

1. The date the Plan terminates;
2. The end of the period for which the last premium has been paid by you;
3. The premium due date coinciding with or next following the date you cease to be a NYSUT Member;
4. Upon your death;
5. The date you, the covered NYSUT Member, request termination of coverage in writing (signature required); or
6. The date the NYSUT Member is no longer covered by or insured under a Basic Plan.

Date coverage ends for covered dependents

A dependent's coverage ends at the earliest of:

1. The date your (the covered NYSUT Member's) coverage ends;
2. The date the Plan terminates or eliminates coverage for dependents under the Plan;
3. With respect to children, the end of the month in which the child ceases to be a dependent as defined by the Plan;

4. With respect to an unmarried child who is primarily supported by you and incapable of self-sustaining employment by reason of disability, the end of the month in which the child marries, is no longer primarily supported by you or is no longer incapable of self-sustaining employment by reason of disability;
5. With respect to a spouse, domestic partner or parent-in-law, the end of the month in which the person ceases to be a lawful spouse, domestic partner or parent-in-law of the member;
6. The end of the period for which the last premium has been paid for the dependent;
7. The date you request termination of a dependent's coverage in writing; or
8. The date the dependent is no longer covered by or insured under a Basic Plan.

RESCISSION

The Plan reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the Plan will not terminate/rescind coverage retroactively (as opposed to prospectively) except in certain instances, such as you or your covered dependent(s) commits fraud or intentional misrepresentation (for example, in enrollment materials, a claim, or appeal for benefits or in response to a question from the Plan Administrator or its designee). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice and you will have the opportunity to appeal. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium (including COBRA premiums). The failure to report a divorce is considered a failure to pay required COBRA premium and coverage will be rescinded retroactive to date of divorce.

END OF COVERAGE IF PREMIUM IS NOT PAID - GRACE PERIOD

Each premium, after the first, may be paid up to 31 days after its due date. This period is the grace period. The coverage will stay in effect during this period. If the premium is not paid by the end of this period, coverage under the Plan will end at that time.

CONTINUATION OF COVERAGE

Coverage for you and your covered dependents will continue while the Plan is in force and as long as the required premium is paid within the guidelines set by the Plan.

There is an option for you (the covered NYSUT Member) to continue your coverage should your NYSUT membership lapse. In addition, there is an option for your covered dependents to continue coverage should your NYSUT membership lapse, your children become too old to be covered under the Plan, you die, or you become divorced or legally separated.

You or your covered dependents must contact the Administrator no later than 60 days after the event occurs (i.e., your NYSUT Membership lapses, you die, or you divorce/legally separate; or a covered child attains age 30), in order to choose any of the continuation options described below.

Premiums will be adjusted to reflect the covered person's age. If a refund of premium is due upon your death, it will be paid to your estate.

If you or your covered dependents were continuing coverage as of December 31, 2017, you and/or they may continue that coverage.

Continuation of coverage for the NYSUT Member whose NYSUT membership lapses

Should your (the covered NYSUT Member's) NYSUT membership lapse, you can choose COBRA continuation coverage and pay the required premium, which will allow you and your covered dependents to remain covered under the Plan for a limited time (generally 18 months) as described below. Once the COBRA continuation period is over, the coverage will end.

Should a covered dependent also be a NYSUT Member at the time the covered NYSUT Member's membership lapses, the covered dependent also has the option to continue coverage under the covered dependent's own NYSUT ID number until the date coverage would end for a covered NYSUT Member. In this circumstance, the covered dependent who chooses to continue coverage under the covered dependent's own NYSUT ID number may, at the same time only, also elect to cover the former NYSUT Member whose membership lapsed as a dependent if the former NYSUT Member satisfies all other eligibility requirements for coverage as a dependent. The former NYSUT Member's coverage would then continue until the date coverage would end for a covered dependent. The covered dependent who chooses to continue coverage under the covered dependent's own NYSUT ID number may, at the same time only, also elect to cover the former NYSUT Member's covered dependents who satisfy all other eligibility requirements for coverage as a dependent. Coverage for such dependents would then continue until the date coverage would end for a covered dependent.

Continuation of coverage for dependents who lose coverage

When your covered dependent ceases to meet the eligibility requirements under the Plan (e.g., a child reaches age 30 or is no longer disabled; or you and your spouse divorce; or you die), your covered dependent can no longer be covered under the Plan as your dependent. However, your covered dependent can choose COBRA continuation and pay the required premium, which will allow your covered dependent to remain covered under the Plan for 36 months. Once the 36 months is over, the covered dependent's coverage will end.

Should your covered dependents lose coverage because your NYSUT membership lapses, they may choose COBRA continuation coverage and pay the required premium even if you do not choose COBRA continuation coverage, which will allow them to remain covered under the Plan for a limited time (generally 18 months) as described below.

Should a covered dependent also be a NYSUT Member at the time the qualifying event occurs (e.g., a child reaches age 30 or is no longer disabled; or you and your spouse divorce; or you die), the covered dependent also has the option to continue coverage under the covered dependent's own NYSUT ID number until the date coverage would end for a covered NYSUT Member. In the circumstance that you (the covered NYSUT Member) die or divorce, and your covered surviving or ex-spouse, who is also a NYSUT Member, elects to continue coverage under the covered surviving or ex-spouse's own NYSUT ID number, the surviving or ex-spouse may, at the same time only, also elect to cover your covered dependents who satisfy all other eligibility requirements for coverage as a dependent. Coverage for such dependents would then continue until the date coverage would end for a covered dependent.

CONTINUATION COVERAGE RIGHTS UNDER COBRA – GENERAL NOTICE

Federal law requires that you be provided with a General Notice of your continuation rights under COBRA upon becoming covered under this Plan:

IMPORTANT INFORMATION - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. **For more information about COBRA continuation rights and obligations under the Plan and under federal law, you should contact AMBA, at P.O. Box 9186, Des Moines, IA 50306-9186.**

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

Keep in mind that because you must maintain enrollment in a Basic Plan, if you lose that other coverage, you will not be eligible for benefits under this Plan. Therefore, you will have to purchase COBRA under the Basic Plan (or be covered under another group health plan/Basic Plan) in order to be eligible for benefits under this Plan if you decide to purchase COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a Life Event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, dependent children, parents and parents-in-law could become qualified beneficiaries, if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a NYSUT Member, you will become a qualified beneficiary if you lose your coverage under the Plan because the following qualifying event occurs:

- Your NYSUT Membership ends.

If you are the spouse of a NYSUT Member, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse (the covered NYSUT Member) dies;
- Your spouse's (the covered NYSUT Member) NYSUT membership ends; or
- You become divorced or legally separated from your spouse.

If you are a dependent child, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occurs:

- Your parent (the covered NYSUT Member) dies;
- Your parent's (the covered NYSUT Member) NYSUT membership ends; or
- You (the child) stops being eligible for coverage under the plan as a "dependent child."

If you are a parent or parent-in-law, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occurs:

- Your son/daughter or son/daughter-in-law (the covered NYSUT Member) dies;
- Your son's/daughter's or son/daughter-in-law's (the covered NYSUT Member) NYSUT membership ends; or
- You stop being eligible for coverage under the Plan as a parent-in-law because your son/daughter-in-law divorces or is legally separated from your child.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Administrator has been notified that a qualifying event has occurred. The Administrator must be notified within 60 days after the qualifying event has occurred.

All notices of qualifying events must be sent to: AMBA, P.O. Box 9186, Des Moines, IA 50306-9186. The notice should include the current date, your name, address, phone number, NYSUT ID and name of the NYSUT Member, the name of the qualified beneficiary(ies), the type of qualifying event, the date the qualifying event occurred, the signature of the person notifying the Administrator of the qualifying event, and supporting documentation, as applicable (e.g., a copy of the dated signature page of the divorce decree or separation agreement).

How is COBRA coverage provided?

Once the Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered NYSUT Members may elect COBRA continuation coverage on behalf of their spouses and/or children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the NYSUT Member, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is due to the end of NYSUT membership, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Administrator in writing within 60 days of receipt of the Social Security

Disability Award, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage, if the NYSUT Member or former NYSUT Member dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. Keep in mind that if you do enroll in coverage through the Marketplace or Medicaid, you will not be eligible for benefits under this Plan unless you are also covered under a Basic Plan.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to **AMBA, P.O. Box 9186, Des Moines, IA 50306-9186.** For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

In order to protect your family's rights, you should keep the Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrator.

IV. BENEFITS, EXCLUSIONS AND LIMITATIONS

The Plan reimburses a percentage of expenses for Medically Necessary Covered Charges after your Basic Plan(s) has paid its benefits, you have met the annual Deductible, and you have satisfied any applicable benefit eligibility criteria. What the Plan reimburses depends on whether you used a provider who was considered an In-Network provider or an Out-of-Network provider under the Basic Plan (as described below and outlined in the Summary of Benefits). If you receive medical services or supplies from a provider who contracted with the network of the Basic Plan (In-Network), this Plan will reimburse you a higher percentage of your associated out-of-pocket costs than if you receive medical services or supplies from a provider that does not contract with the network of your Basic Plan (Out-of-Network).

For prescription drugs, what the Plan reimburses depends on whether your prescribed medication is considered In-Network or Out-of-Network by your Basic Plan. Prescribed medications that are considered Out-of-Network by your Basic Plan are subject to a higher cost-sharing, and the amount you pay does not count toward the In-Network out-of-pocket maximum.

DEDUCTIBLE

The Deductible is the amount you owe before the Plan begins to pay benefits.

	In-Network	Out-of-Network
Overall Annual Out-of-Pocket Deductible	$2,000/Individual $4,000/Family	$5,000/Individual

Overall Annual Out-of-Pocket Deductible: Each calendar year, you (and not the Plan) are responsible for paying all Covered Charges until you satisfy the overall annual Deductible. Once you have satisfied the overall annual Deductible, the Plan begins to pay benefits pursuant to the terms of this Plan Document. The Deductible amounts are listed in the Summary of Benefits found at the beginning of this document and above. The family In-Network annual Deductible can be satisfied by a combination of family members, but under no circumstance will any one individual be required to exceed the individual Deductible.

Deductibles are applied to the Covered Charges in the order in which claims are processed by the Plan and accumulated on a calendar year basis. Only Covered Charges can be used to satisfy the Plan's Deductibles. As a result, non-eligible charges do not count toward the Deductibles. Note that In-Network and Out-of-Network Deductibles are NOT interchangeable, meaning you may not use any portion of an In-Network Deductible to meet an Out-of-Network Deductible and vice versa. Expenses for preventive services are not subject to a Deductible, as explained in this section.

Please note: You are not required to satisfy the overall annual Deductible in order to access the convalescent/custodial care, Nursing Home, Assisted Living Facility, home health care and Critical Illness benefits. Refer to those sections for more details.

BENEFIT PERIOD

Benefits are payable when a participant incurs Covered Charges in excess of the annual Deductible. This Plan's Benefit Period is the calendar year and runs from January 1 to December 31.

The maximum amount of benefits to be paid for each participant is shown in the Summary of Benefits.

For Benefit Period effective dates on or before December 31, 2017, the Prior Plan(s) apply.

No benefits will be payable under the Plan during the period for which benefits are payable under the Prior Plan in accordance with the terms of the Prior Plan. After such period, benefits will be payable under the Plan provided that benefits in excess of the maximum benefit under the Plan shown in the Summary of Benefits have not been paid. The maximum benefit under the Plan includes benefits paid under the Prior Plan plus any benefits paid under the Plan.

Notwithstanding the prior paragraph, benefits for home health care payable under the terms of the Prior Plan will not count toward the 6,000-hour lifetime maximum under the Plan. In addition, benefits for Hospice care payable under the terms of the Prior Plan will not count toward the 210-consecutive day lifetime maximum under the Plan.

IN-NETWORK OUT-OF-POCKET MAXIMUM

The In-Network out-of-pocket maximum is the most you pay for In-Network health care services for Essential Health Benefits during a one-year period (the calendar year) before the Plan starts to reimburse 100% for Covered Charges received from In-Network providers under a Basic Plan.

You should note that there is no out-of-pocket maximum when you use Out-of-Network providers. No Covered Charges for expenses for Out-of-Network count toward the In-Network out-of-pocket maximum, except Emergency Services performed in an Out-of-Network emergency room will accumulate to meet the In-Network out-of-pocket maximum. Covered expenses are applied to the out-of-pocket maximum in the order in which eligible claims are processed by the Plan. The amount of the out-of-pocket maximum may be adjusted in accordance with the amount published by the Department of Health and Human Services.

You should also note that the following Covered Charges are NOT considered "Essential Health Benefits" and do not accumulate toward the out-of-pocket maximum:

- Convalescent/custodial care provided in a Convalescent Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility; and
- Private Duty Nursing.

COVERED CHARGES

"Covered Charges" refers to those amounts that are considered in satisfying the Deductible and/or are payable as benefits under the Plan. Covered Charges are determined by the Plan Administrator or its designee and are limited to those that are:

- Incurred by the claimant during the calendar year;
- Medically Necessary, but only to the extent that the charges are Covered Charges;
- For the diagnosis or treatment of an injury or illness (except for the preventive services payable by the Plan);
- Not services or supplies that are excluded from coverage (as described later in this section); and
- Not services or supplies in excess of any applicable maximum as shown in the Summary of Benefits.

The Plan will not reimburse you for any expenses that are not covered medical benefits or are not considered eligible medical expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Plan's Covered Charge, not covered by the Plan, or in excess of a maximum Plan benefit.

The Covered Charge is determined by the Plan Administrator or its designee and means the dollar amount the Plan has determined it will allow for covered expenses as follows:

- With respect to In-Network providers under your Basic Plan, the Covered Charge is the out-of-pocket cost incurred by you when accessing care via your Basic Plan;
- For Out-of-Network providers, the Covered Charge is the lesser of the Basic Plan allowance or the 80th percentile of the Fair Health Fee Schedule (updated semi-annually);
- Notwithstanding the above, if the provider's actual billed charges are lower than any of these two (2) amounts, the billed charges will be considered the Covered Charge; and
- For prescription drugs, the Covered Charge for a drug will be based on your share after the Basic Plan allowance.

Please note:

- Only charges that are actually incurred and paid are considered Covered Charges under the Plan;
- Amounts in excess of Covered Charges, as well as services that are not covered, will not be considered Covered Charges and will not be applied to the Deductible;
- The Plan will not reimburse you for any expenses that are not determined to be Covered Charges;
- The Administrator reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the Covered Charge amount; and
- The Administrator reserves the right not to base its benefits determination on the Physician's or health care provider's actual charge for health care services or supplies.

The Plan only reimburses Covered Charges as described below:

1. Covered Charges for inpatient Hospital services for acute care or treatment given or ordered by a health care professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:
   - Semiprivate room and board (private rooms covered only if Medically Necessary);
   - The use of intensive care, special care or cardiac care units and equipment;
   - General, special and critical nursing care;
   - Meals and special diets;
   - The use of operating, recovery and cystoscopic rooms and equipment;
   - Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
   - Dressings and casts;
   - Services and supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;

- Blood and blood products except when participation in a volunteer blood replacement program is available;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Additional medical services and supplies which are provided while you are a registered bed patient and which are billed by the Hospital.

  Please note: Such services and supplies listed above will not be covered if they are provided mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, or any Physician, provider, Hospital or facility.

2. Covered Charges for Emergency Services for:
    - Emergency Services for the treatment of an Emergency Medical Condition will be the same for In-Network and Out-of-Network providers but only to the extent those Emergency Services and supplies are Medically Necessary and are performed to treat or stabilize the Emergency Medical Condition in a Hospital; and
    - Non-Emergency Services in an emergency room will be paid like other Hospital services.

3. Covered Charges made by a Physician for:
    - Diagnosis;
    - Treatment;
    - Surgery; and
    - Diagnosis and treatment, including outpatient visits, of mental health and substance use disorders.

4. Covered Charges made for private duty nursing, while in a Hospital or at home, by a registered nurse or licensed practical nurse who is not a member of the participant's immediate family or household, up to the amount shown in the Summary of Benefits. If services are rendered while in a Hospital, the Physician must indicate what services will be rendered that the Hospital's staff nurses cannot perform and why.

5. Covered Charges for physiotherapy given by a licensed physiotherapist.

6. Covered Charges for ambulance service to or from a Hospital.

7. Covered Charges for Outpatient and Professional Services (when Medically Necessary):
    - Acupuncture for up to 30 visits per calendar year;
    - Advanced Imaging services (PET scans, MRI, nuclear medicine, and CAT scans);
    - Allergy testing and treatment;
    - Ambulatory surgical center services;
    - Anesthetics and their administration;
    - Bariatric Surgery;
    - Blood and blood plasma (to the extent not replaced by donors);
    - Chemotherapy;
    - Chiropractic Services for up to 30 visits per calendar year;
    - Dialysis;

- Drugs which by law may only be dispensed with a prescription (except as required by the Affordable Care Act as described in the Preventive Benefits Section). Covered Charges for drugs used in the treatment of cancer will not be excluded on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration, provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been:
  a. Prescribed in one of the following reference compendia:
     - the American Medical Association Drug Evaluations;
     - the American Hospital Formulary Service Drug Information; or
     - the United States Pharmacopeia Drug Information.
  b. Recommended by review article or editorial comment in a major peer reviewed professional journal.

  In no event, however, will coverage be provided for any Experimental or Investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed;
- Fertility and Infertility Services are payable for the diagnosis and treatment of medical conditions that result in infertility but not for expenses related to services that induce pregnancy including but not limited to surgical impregnation procedures like in-vitro fertilization;
- Infusion Therapy;
- Interruption of pregnancy;
- Maternity and newborn care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center including prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy;
- Office visits for the diagnosis and treatment of injury, disease and medical conditions;
- Outpatient Hospital services and supplies as described in the Hospital subsection above that can be provided to you while being treated in an outpatient facility;
- Oxygen;
- Preadmission testing;
- Reconstructive and Corrective Surgery;
- Rehabilitation services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a facility or in a provider's office for up to a total of 30 visits per calendar year;
- Second/third surgical opinions;
- Services related to sex change; Services and supplies related to gender dysphoria including but not limited to, Medically Necessary services and supplies for counseling, surgery, durable medical equipment and prescription drugs, in the same way as other medical or surgical services and supplies subject to the Plan's general medical management requirements;
- Surgical services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care; benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant;
- Telemedicine;
- Transplants;
- Urgent care;

- Use of radium and radioactive isotopes; and
- X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

8. Covered Charges for Durable Medical Equipment, Prosthetics and Medical Supplies (to buy, rent, repair or maintain):
   - Prosthetic devices that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease (e.g., artificial limbs);
   - Crutches;
   - Braces;
   - Durable medical equipment which is designed and intended for repeated use, used to serve a medical purpose, not useful to a person absent disease or injury and appropriate for use in the home including wheel chairs and other medical equipment and appliances; and
   - Medical supplies required for treatment of a disease or injury which is covered under this Plan.

9. Covered Charges made for Hospice care, as follows:
   - Covered Charges made by a Hospice, up to 210 consecutive days of confinement per lifetime while covered under this Plan; and
   - Covered Charges for five (5) visits per lifetime while covered under this Plan for bereavement counseling to the family of the terminally ill participant. Family means the parent, spouse, sibling or child of the terminally ill participant.

10. Covered Charges made for Skilled Nursing Services in a Skilled Nursing Facility or Subacute Care Facility for active and progressive treatment up to a lifetime maximum of 100 days. The confinement must be ordered or prescribed by a Physician. Custodial care in a Skilled Nursing Facility is not payable under this provision and is payable in accordance with #11 below.

11. Covered Charges for confinement for convalescent/custodial care made by a Medicare-certified Convalescent Home, Custodial Care Facility, Nursing Home or Skilled Nursing Facility, and Covered Charges for confinement for convalescent/custodial care made by an Assisted Living Facility that is licensed to operate under the laws of the state in which it is located: Up to $72 per day benefit with a maximum lifetime benefit of $80,000.

    Benefits begin on the 20th day of confinement. The confinement must be due to an injury, sickness or condition for which benefits are payable under the Plan. The confinement must be prescribed by the attending Physician.

    Benefits will not be paid for both convalescent/custodial care and home health care received on any given day. If the participant is receiving home health care while in an Assisted Living or other facility where convalescent/custodial care is being received, claims will be paid based only on the higher claim amount.

12. Covered Charges made for home health care, as follows:
    - Part-time or intermittent home nursing care by, or supervised by, a registered nurse;
    - Part-time or intermittent home health aide services which mainly care for the patient;
    - Occupational, speech, respiratory or physical therapy;

- Medical social work; and
- Special meals and nutritional services.

Benefits are payable when a plan of care is provided for home health care and care is:

- Provided by a Home Health Care Agency that is Medicare-certified or licensed or certified by a state department of health or other state regulatory authority responsible for licensing or certifying Home Health Care Agencies;
- In lieu of confinement in a Hospital or Skilled Nursing Facility;
- Set up and approved, in writing, by a Physician;
- Provided by a trained certified home health care provider, and cannot be provided by a family member; and
- Provided under a treatment plan that is prescribed by a Physician and is documented with a daily log kept by the home health care provider of services performed on behalf of the patient.

Benefits will begin following 60 hours of paid home health care per calendar year and will be paid up to 25 hours of home health care per calendar week up to a maximum of 6,000 hours per lifetime.

Home health care benefits provided by a licensed or certified individual caregiver who is not employed by a Home Health Care Agency that is Medicare-certified or licensed or certified by a state department of health or other state regulatory authority responsible for licensing or certifying Home Health Care Agencies will be paid at 30% of the Covered Charge. All the other criteria listed above would apply.

Benefits will not be paid for both convalescent/custodial care and home health care received on any given day. If the participant is receiving home health care while in an Assisted Living or other facility where convalescent/custodial care is being received, claims will be paid based only on the higher claim amount.

13. Covered Charges for Behavioral Health Services (Mental Health and Substance Abuse Treatment) are as follows:
    - Inpatient acute Hospital admission and residential treatment program; and
    - Outpatient visits including necessary psychological (psychiatric) testing, Partial Day Care/Partial Hospitalization and Intensive Outpatient Program (IOP) care.

PREVENTIVE BENEFITS

The Plan reimburses your out-of-pocket costs after application of your Basic Plan's coverage for the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost-sharing (deductibles or coinsurance) when received from any provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, cost-sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply. You may contact the Administrator for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

Please visit the USPSTF home page to review the most current coverages of preventive benefits at https://www.uspreventiveservicestaskforce.org/uspstf/.

CLINICAL TRIALS

The Plan reimburses your out-of-pocket charges for routine patient costs associated with Approved Clinical Trials the same as if the costs were not related to participation in a clinical trial (as outlined in the Summary of Benefits). An Approved Clinical Trial is a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that meets the requirements of the definition of "Approved Clinical Trial" found in the definitions section of this Plan Document. An individual will qualify for participation in an Approved Clinical Trial based on a referral from a physician or an Allied Health Professional participating in the trial, or by providing medical and scientific information establishing that participation would be appropriate.

Routine patient costs include all items and services consistent with the coverage provided under the Plan for a person not enrolled in a clinical trial.

Routine patient costs **do not** include, and reimbursement will not be provided for:

- The investigational item, device, drug, or service;
- Services or supplies listed as Exclusions in this Plan Document;
- Services or supplies related to data collection for the clinical trial (i.e., protocol induced costs);
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Services or supplies, which in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by the manufacturer and not yet FDA approved) without charge to the trial participant; or
- Travel and transportation expenses (including lodging and meals) unless otherwise covered under the Plan.

RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY

This Plan reimburses your out-of-pocket costs associated with benefits provided pursuant to the Women's Health and Cancer Rights Act (WHCRA). WHCRA provides that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:

- 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 physical complications for all stages of mastectomy, including lymphedemas.

Coverage for mastectomy-related services or benefits will be subject to the same payment provisions that apply with respect to other medical or surgical benefits provided under this Plan.

HOSPITAL LENGTH OF STAY FOR CHILDBIRTH

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 newborn child 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 a plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage will be subject to the same payment provisions that apply with respect to other medical or surgical benefits provided under this Plan.

CRITICAL ILLNESS BENEFIT

The Critical Illness benefit of $1,000 is payable in a lump sum upon the diagnosis of a Critical Illness by a Physician. No Deductible applies to this benefit, and it is payable one time while eligible for benefits under the Plan.

"Critical Illness" means a heart attack, stroke, terminal illness, cancer, quadriplegia or an illness requiring coronary bypass surgery or a major organ transplant.

"Heart Attack" means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include all of the following criteria: 1) EKG findings consistent with Myocardial Infarction; 2) elevation of cardiac enzymes above generally accepted laboratory levels of normal; and 3) chest pains.

"Stroke" means a cerebral vascular accident or incident. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. The Plan will pay a benefit for Stroke which produces permanent neurological sequela persisting for at least 30 days following an initial diagnosis. The Claim Administrator must receive evidence of the permanent neurological damage provided by a CAT scan or MRI.

"Terminal Illness" means a medical condition: 1) which is expected to result in the participant's death within 12 months; and 2) from which the participant is not expected to recover.

"Cancer" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer includes leukemia. Excluded are cancers such as: 1) pre-malignant tumors or polyps; 2) cancer in-situ, intraductal non-invasive carcinoma of the breasts; 3) any skin cancers except melanomas; or 4) Stage 1 Hodgkin's Disease. The Plan will not exclude a clinical diagnosis of cancer if, in the opinion of the attending Physician, a positive diagnosis cannot otherwise be made without jeopardizing the life of the participant. In any event, there must be a definitive treatment for cancer.

"Quadriplegia" means the complete and permanent loss of the use of all four limbs through paralysis for a continuous period of 180 days, as confirmed by a Physician.

"Coronary Bypass Surgery" means bypass surgery using either the saphenous vein or internal mammary artery graft for the treatment of coronary artery disease. The surgery must be performed for the treatment of coronary artery disease to correct a severe stenosis: 1) in the main trunk or left coronary artery; and

2) proximal stenosis of major coronary branches. The Administrator must receive: 1) a confirmation by a consulting cardiologist; and 2) angiographic evidence of the underlying disease.

"Major Organ Transplant" means surgery to transplant any of the following organs: heart, kidney, lung, liver or bone marrow. Major Organ Transplant does not include transplanted organs from non-human donors.

BENEFITS COVERED WITH LIMITATIONS

Benefits will be paid for Covered Charges incurred for the medical services shown below only to the extent described below.

Treatment for temporomandibular joint dysfunction (TMJ): Charges for these services will be considered Covered Charges but shall not include orthodontic care, prosthetic devices, crowns or bridgework.

Eye exams to prescribe or fit corrective lenses for eyeglasses: Charges for these services will be considered Covered Charges only if they result from a Non-Job Related Injury.

Cosmetic treatment or surgery: Charges for these services will be considered Covered Charges only if they result from:

- A Non-Job Related Injury or Sickness; or
- A congenital disease or anomaly of a dependent child resulting in a functional defect.

GENERAL EXCLUSIONS

No medical care benefits will be paid by the Plan for charges incurred for treatment:

- Given after a participant's coverage ends, regardless of when the injury or sickness occurred;
- That is not Medically Necessary for the Necessary Care or Treatment of the injury or sickness involved;
- That is related to custodial care or transportation except for the services that are specifically outlined in this document. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities;
- That would be given free of charge if the participant was not covered. However, medical care benefits will be paid for Covered Charges incurred by a state for medical assistance to a covered participant under Medicaid;
- Which results from a war or an act of war;
- Which results from intentionally self-inflicted injury. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions);
- That is given by a participant's spouse, father, mother, son, daughter, brother or sister or the participant's spouse's father, mother, son, daughter, brother or sister;
- That is given by a participant's employer or an employee of such employer; or
- That is given while serving on full-time active duty for more than 30 consecutive days in the Armed Forces of any country or international authority. (The Plan will refund premium on a pro rata basis for any such period of full-time active duty).

No benefits will be paid by the Plan for charges incurred for:

- Dental care, treatment or surgery of any kind;
- Any health care service, procedure, treatment, device, prescription drug or confinement that is Experimental or Investigational, or that results therefrom;
- Medical marijuana;
- Services that are not specifically listed in this Plan as being covered;
- Expenses for preparing or completing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, lodging costs, provider administration fees, concierge/retainer agreement/direct primary care fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees;
- Services or supplies provided outside the United States except as described here. The term "outside the United States" means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. This Plan follows the Medicare guidelines in determining in what circumstances such expenses would be covered. There are 3 situations when this Plan would pay health care services received in a Hospital outside the United States:
  - In a medical emergency if the patient is in the United States but a foreign hospital is closer than the nearest U.S. Hospital that can treat the illness or injury;
  - If the patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian Hospital is closer than the nearest U.S. Hospital that can treat the illness or injury; or
  - The patient lives in the U.S. and the foreign Hospital is closer to their home than the nearest U.S. Hospital that can treat the medical condition, regardless of whether it is an emergency;
- The difference between the cost of a semi-private room in a Hospital or Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Administrator or its designee) to be Medically Necessary;
- Any amount in excess of the Covered Charges allowable under this Plan (e.g., balance billing by a provider);
- Any amount in excess of the negotiated fees of an In-Network provider under a Basic Plan;
- Any amount of reduction by a Basic Plan because a participant did not comply with the Basic Plan's provisions, such as the provisions related to utilization management or pre-certification;
- Expenses for services received because of an occupational sickness or injury;
- Purchase or rental of:
  - Air conditioners;
  - Air purifiers;
  - Motorized transportation equipment; escalators or elevators in private homes;
  - Eye glass frames or lenses;
  - Hearing aids;
  - Swimming pools or supplies for them; or
  - General exercise equipment;
- A routine physical exam, except as provided in the Preventive Benefits section;
- Bed holds in a Convalescent Home or Custodial Care Facility;

- Weight Loss programs. This provision does not apply to obesity screening, intensive counseling and behavioral interventions for obesity as covered under the Preventive Benefits section; or
- Routine foot care: Routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition and sensation. However, routine foot care administered by a podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

V. CLAIMS

For claims filed with a Benefit Period effective date on or before December 31, 2017, a Prior Plan applies. No benefits will be payable under the Plan during the period for which benefits are payable under the Prior Plan in accordance with the terms of the Prior Plan. After such period, benefits will be payable under the Plan provided that benefits in excess of the maximum benefit under the Plan shown in the Summary of Benefits have not been paid. The maximum benefit under the Plan includes benefits paid under the Prior Plan plus any benefits paid under the Plan.

Notwithstanding the prior paragraph, benefits for home health care payable under the terms of the Prior Plan will not count toward the 6,000-hour lifetime maximum under the Plan. In addition, benefits for Hospice care payable under the terms of the Prior Plan will not count toward the 210-consecutive day lifetime maximum under the Plan.

This Plan is a voluntary excess plan and will always pay secondary (or tertiary and so forth) after the participant's Basic Plan (or Plans) has paid claims. If you are not enrolled in a Basic Plan at the time the claim was incurred, this Plan will not pay any benefits.

Unless a specific Coordination of Benefits rule in this Plan Document states otherwise, this Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums. The Plan will never pay more than 100% of the Covered Charges. In no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first. As a result, you may not receive the equivalent of 100% of the total cost of the health care services especially if you use an Out-of-Network provider.

Administration of Payment

1. To administer secondary payments under this Plan, the Plan reserves the right to:
   - Exchange information with other plans involved in paying claims;
   - Require that you or your provider furnish any necessary information; or
   - Recover any overpayment from you, your dependents, a provider or insurance company.

2. To obtain benefits under this Plan, your claim must be fully processed (including any appeals) under all Basic Plans that cover the person for the expenses that were incurred. Any person who claims benefits under this Plan must provide all the information the Plan needs to process the claim.

3. If a participant is not covered by a Basic Plan when a claim is incurred, no benefits will be payable by this Plan.

COORDINATION OF BENEFITS WITH MEDICARE

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period). This Plan requires that retired participants who are age 65 and over be enrolled in Medicare with the exception of retired participants who are Medicare-eligible but who are covered as a dependent under their spouse's Basic Plan provided that such plan is primary to Medicare.

If a participant is covered under a Basic Plan and Medicare Parts A and B (or a Medicare Advantage Plan (Part C)) and Part D, Medicare will pay its benefits first, the Basic Plan will pay its benefits second and this Plan will pay its benefits third.

If a participant is only enrolled in Medicare Parts A and B (or a Medicare Advantage Plan (Part C)) and Part D, Medicare will pay its benefits first and this Plan will pay its benefits second.

If, while covered under an active Basic Plan, a participant under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), the Basic Plan pays first, this Plan pays second and Medicare pays third for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first, the Basic Plan pays second and this Plan pays third.

How Much this Plan Reimburses When it is Secondary to Medicare

When a participant is only covered by Medicare Parts A and B (and not another Basic Plan) and this Plan is secondary to Medicare, this Plan reimburses the same percentages of Covered Charges, less payments by Medicare, as it would for individuals who are not Medicare-eligible. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the provider. You must be enrolled in a Medicare Part D Plan or have Creditable prescription drug coverage (as defined by Medicare) through another Basic Plan to be eligible to have your out-of-pocket prescription drug costs reimbursed under this Plan.

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract, this Plan will consider such services as Out-of-Network and pay benefits according to the Summary of Benefits.

COORDINATION WITH GOVERNMENT AND OTHER PROGRAMS

In order to be eligible for this Plan, a participant must be enrolled in a Basic Plan. If a participant is also enrolled in one of the following programs, coordination works as follows:

Medicaid: If a participant is covered by Medicaid or a State Children's Health Insurance Program (CHIP), the Basic Plan pays first, this Plan pays second and Medicaid or the State Children's Health Insurance Program (CHIP) pays third.

TRICARE: If a dependent is covered by the TRICARE Program, the Basic Plan pays first, this Plan pays second and TRICARE pays third. For a participant called to active duty for more than 30 days, TRICARE would be primary for active members of the armed services only. If a participant receives services in a military medical Hospital or facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

Veterans Affairs/Military Medical Facility Services: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Covered Charges.

Long-Term Care policies: If a participant is covered by group, blanket, franchise, or individual long-term care, Nursing Home, or home health care insurance coverage, a long-term care rider of a permanent life insurance policy, or any plan which provides coverage for convalescent or custodial care in a Nursing Home or in a private residence, the Basic Plan and any of the above-mentioned policies pay first, and this Plan pays second.

Motor Vehicle Coverage Required by Law: If a participant is covered by any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, the Basic Plan pays second and this Plan pays third. The Plan's benefit coverage is excess to the combined payments from any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault) and Basic Plan(s).

Other Coverage Provided by State or Federal Law: If a participant is covered by any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first, the Basic Plan pays second and this Plan pays third.

INTERNAL CLAIMS AND APPEALS PROCEDURES

GENERAL INFORMATION

This section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical benefits provided by this Plan. The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing a claim denial that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the Administrator about whether a request for benefits (known as an initial "claim") is payable under the terms of the Plan. If the Administrator denies your initial claim for benefits (called a claim denial or denial of claim), you have the right to appeal the denied claim under the Plan's internal appeals process. You may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of denial of claim determinations either (1) after the Plan's internal appeals process has been exhausted, or (2) under limited circumstances before the Plan's internal claims and appeals processes have been exhausted.

Administrator

The Trust has delegated responsibility for initial claims decisions to the Administrator.

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Denial of Claim Determination

A denial of a claim, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

CULTURALLY AND LINGUISTICALLY APPROPRIATE NOTICES

All notices relating to external review sent will contain a notice about the availability of Spanish, Chinese, Tagalog, and Navajo language services. Assistance with filing a claim for external review in Spanish, Chinese, Tagalog, and Navajo is available by calling (844) 552-7805. Notices relating to external review will be provided in Spanish, Chinese, Tagalog, and Navajo upon request.

- SPANISH (Español): Para obtener asistencia en Español, llame al (844) 552-7805.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 552-7805.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码(844) 552-7805.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 552-7805.

DEFINITION OF A CLAIM

A claim is a request for a Plan benefit made by you or your covered dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's claims procedures.

The only claims that apply to this Plan are post-service claims. A post-service claim is a request for benefits under the Plan that is not a pre-service claim. Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim submitted for payment after services have been provided is an example of a post-service claim. A claim regarding the rescission of coverage will be considered to be a post-service claim.

CLAIM SUBMISSION DEADLINE

Claims must be filed within two (2) years of incurring the claim expense. The time period for making a decision on an initial claim request starts as soon as the claim is received in good order by the Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative or a provider.

CRITICAL ILLNESS CLAIM

A claim for the Critical Illness benefit requires that you submit a completed Critical Illness Claim Form. Claims must include the following:

- A completed Attending Physician's Statement section; and
- A pathology report for cancer diagnoses confirming the diagnosis.

FILING A CLAIM

A claim or request for Plan benefits requires that you submit a completed claim form. In order to accurately process your claim, an initial claim must include the following elements to trigger the Plan's internal claims process:

- Completed and signed claim form;
- Be received by the Administrator;
- Name a specific individual participant and the participant's NYSUT ID number;
- Name a specific claimant and the claimant's date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN);
- Include a copy of the Explanation of Benefits (EOB) from all your basic health insurance plans;
- Include all itemized invoices;
- Include proof of payment (e.g., receipts, cancelled checks, etc.); and
- Letters of Medical Necessity from your Physician (if applicable and requested by the Administrator).

Each document mentioned above provides valuable information on your claim. Other documents may also be required by the Administrator to complete your claim and you will be notified by the Administrator, if necessary. In addition, if you submit a claim that is not complete or lacks required supporting documents, the Administrator, will notify you about what information is necessary to complete the claim.

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, your (or your covered dependent's) authorized representative or provider;
- Made by an unidentified person (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;

- A request for prior approval as prior approval is not required by the Plan; or
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as a denial of a claim and the individual will be notified of the decision and allowed to file an appeal.

To file a claim, follow these steps:

Step 1:

Contact the Administrator by phone, mail or website to obtain a claim form.

Step 2:

Complete the claim form. Include all supporting EOB's, itemized invoices, receipts, proof of payment (e.g. receipt from provider, cancelled checks) and any additional documentation. Mail completed form and supporting documents to the Administrator. Retain copies for your records.

Step 3:

When a claim is processed by the Administrator, you will be sent a document called an Explanation of Benefits (EOB). The EOB describes how the claim was processed, such as Covered Charges, amounts applied to your Deductible, if certain services were denied and why, and how to appeal a claim. When applicable, if the claim is incomplete and/or missing information, you will be told what additional information is required from you. Refer to the Coordination of Benefits section for details on how the Plan pays claims.

PAYMENT OF CLAIMS

All benefits will be paid as they accrue.

BENEFITS PAYABLE TO DECEASED PARTICIPANTS

Benefits due to a deceased participant that have been assigned to the provider will be paid to the provider.

If benefits are due to a deceased participant who is a covered dependent of the NYSUT Member and the benefits have not been assigned to the provider, the Plan will pay the benefits to the NYSUT Member.

If benefits are due to a deceased participant who is the NYSUT Member and the benefits have not been assigned to the provider, the Plan will pay the benefits to the executor or administrator of the participant's estate. If no estate has been created and no estate is in the process of being created, the Plan will determine the beneficiary according to the following order:

1. Your spouse or domestic partner;
2. Your child(ren), in equal shares, if there is no surviving spouse or domestic partner;
3. Your parent(s), in equal shares, if there is no surviving child;
4. Your sibling(s), in equal shares, if there is no surviving parent.

However, if the deceased participant is the NYSUT Member and benefits are unassigned, the Plan will not pay benefits totaling more than $10,000 without a court order or appointment of an executor or administrator.

Any payment by the Plan to a beneficiary in good faith in accordance with the rules set forth above will discharge the Plan's liability.

If a beneficiary is a minor or incompetent to receive payment, the Plan will pay that person's legal guardian for the benefit of the beneficiary.

INITIAL DETERMINATIONS OF BENEFIT CLAIMS

For properly filed claims, you will be notified of a decision within 30 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan and/or Administrator. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Administrator requires additional information, you will be sent an EOB which will specify the information needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be considered closed until the additional information is supplied by you and/or your provider, and the normal period for making a decision on the claim will be suspended until the earlier of 45 days or until the date the Administrator receives your written response to the request for information. The Administrator then has to make a decision and notify you in writing. Once the additional information is received by the Administrator, the claim will be reopened and processed accordingly and you will be notified within fifteen (15) days of receipt of the missing information, subject to the Plan's 2-year time limit for filing a claim.

Written Notice of Denial of Claim

If the Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial. The notice of the denial will be given to you in writing and will be included with the EOB that the Administrator will issue when your claim is processed and will explain the reason(s) your claim was denied (in whole or part). The notice of denial must:

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;

- Contain a statement that you have the right to bring a civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request; and
- If the denial was based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request.

RETURN OF OVER PAYMENT

If the Administrator incorrectly pays benefits in excess of those allowed by the Plan, the Plan has the right to recover such excess from:

- Any person to or for whom such payments were made;
- Any other insurer; or
- Any other organization.

IF BENEFITS ARE PAID IN ERROR

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered regardless of how long ago it occurred, and it is determined that the Plan has paid any benefits that you are not entitled to, you are obligated to reimburse the Plan for the erroneous payments. The Plan has the right to seek repayment through any legal means, including the right to reduce future benefit payments for you or your eligible dependents by the amount of the erroneous payment.

MISREPRESENTATION OR FRAUD

If you receive benefits as a result of false information or a misleading or fraudulent representation or omission, you will be required to repay all benefits the Plan erroneously paid and you will be liable for all costs of collection, including attorneys' fees. The Plan reserves the right to reduce future benefit payments by the amount of the payment made because of fraud or misrepresentation.

THIRD PARTY LIABILITY

The Plan does not cover any illness, injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of that third party and against whom a participant or eligible dependent has a claim. However, the Plan will conditionally pay for benefits for such illness, injury, or other conditions while the claim against the third party is being adjudicated, provided you execute an agreement to reimburse the Plan from any recovery from a third party.

If the Plan conditionally pays for benefits in connection with any illness, injury, or other condition for which a third party may be liable or legally responsible, and you recover from a third party, insurance policy, or uninsured/underinsured motorist coverage, you must reimburse the Plan for benefits the Plan conditionally paid from the recovered funds. You must reimburse the Plan from the recovered funds even if the settlement or judgment is less than anticipated and regardless of whether the recovered funds are designated as payment

for medical expenses. Upon settlement of the claim or judgment against the third party, insurance company, or uninsured/underinsured motorist coverage, you must pay the Plan the recovered funds up to the full amount of benefits the Plan paid in connection with said illness, injury, or other condition.

The Plan has a right to first reimbursement of any recovery from a third party, any insurance policy, or any uninsured/underinsured motorist coverage, even if you are not otherwise made whole and without regard to how the recovery is categorized. The Plan's right to reimbursement will not be affected, reduced, or eliminated by the make whole doctrine, comparative fault or regulatory diligence, the common fund doctrine, or any similar doctrine or theory, including the contractual defense of unjust enrichment. Nor shall the Plan's right to reimbursement be reduced by costs or attorneys' fees.

By making payments on your behalf, the Plan is granted a lien on any recovery. The Plan shall be entitled to enforce this lien by way of any remedy permitted by law or equity. By accepting payments from the Plan, you consent to the Plan's lien, agree to cooperate with the Plan to effectuate the Plan's right to reimbursement, and agree to hold any recovery for the benefit of the Plan until the Plan is fully reimbursed.

You must complete and sign an agreement to reimburse the Plan, in such form as the Plan may require, before any benefits are conditionally paid. If you refuse to sign an agreement to reimburse the Plan, or any other such agreement the Plan may require, you will not be eligible for benefits under the Plan for any claims related to the illness, injury, or other condition. In no event shall the failure of the Administrator to require execution of such paperwork diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement. You may not assign any rights or cause of action that you may have against a third party to recover covered expenses without the express written consent of the Plan. You may be requested to agree to subrogate any claim you may have against a third party in favor of the Plan, and you, as a condition of receiving benefits, will be required to fully cooperate with the Plan to extent the Plan pursues any subrogated claim.

If the Plan pays benefits on your behalf and you recover any proceeds from or on behalf of a third party, any insurance policy, or from uninsured/underinsured motorist coverage, and you do not reimburse the Plan, the Plan may offset the amount you owe from future benefit payments. If necessary, the Plan may also take any appropriate legal action against you, asserting all appropriate legal and/or equitable remedies, including but not limited to, suits under ERISA section 502(a)(3).

If Medicare or another Basic Plan pays you benefits in connection with an illness, injury, or other condition for which a third party is or may be liable or legally responsible, the claims that Medicare or the other Basic Plan paid are not covered under this Plan. This is the case even if you are required to reimburse Medicare or the other Basic Plan the amount it paid, in part or in whole, because Medicare or the other Basic Plan has a right of recovery, reimbursement, and/or subrogation.

In no event will this Plan ever reimburse more than would be required pursuant to the terms of this Plan Document.

CLAIM APPEAL PROCESS

Your Rights to Review Documents

You have the right to review documents relevant to your claim. As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, for reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Administrator written comments, documents, records and other information relating to your initial claim for benefits;
- A full and fair review by the Administrator that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- Any new or additional evidence considered, relied upon, or generated by the Administrator (or at the direction of the Administrator) in connection with the denied claim, free of charge. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of denial of claim on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Administrator issues a denial of claim on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of denial of claim on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
- A review that does not afford deference to the initial denial of claim and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial denial of claim that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any denial of claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will consult with a health care professional who:
  - Has appropriate experience in the field of medicine involved in the medical judgment; and
  - Is neither an individual who was consulted in connection with the initial denial of claim that is the subject of the appeal nor the subordinate of any such individual; and
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a denial of claim without regard to whether the advice was relied upon in making the benefit determination.

You will lose your right to bring legal action against the Plan if you fail to follow the Plan's claims and appeal procedures in a timely fashion (see the *Limitation on When a Lawsuit May Be Started* section).

Request for Review of Denied Claim – Right to Appeal

The Plan maintains a two level appeal process that is described below. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.

Level 1 Appeal: If your claim is denied, or if you disagree with the amount paid on a claim, you (or other representative you authorize on your behalf) may ask for a review by the Administrator (an Appeal Request). Your request for review or reconsideration of a denied claim (a Level 1 Appeal request) must be made in writing to the Administrator within 180 days of the date on the EOB. If any additional information is needed to process your request for review, it will be requested promptly. The decision on any review of your claim will be given to you in writing. It will explain the reasons for the decision, with reference to the applicable provisions of the Plan.

A decision will be reached within 30 days after receipt of your request for review.

Level 2 Appeal (Final Level of Appeal): If you are dissatisfied with the outcome of the Level 1 Appeal determination, you may ask for a Level 2 review. You must submit your written request to the Administrator within 60 days after you receive the Level 1 Appeal decision. The Administrator will forward your request for further review to an independent third party, together with any additional information you have in support of your request. The independent third party reserves the right to utilize the assistance of an independent medical review firm in the research and resolution of a claim appeal.

A decision on this review of your claim will be given to you in writing, explaining the reasons for the decision, with reference to the applicable provisions of the Plan. This decision will be reached within 30 days after receipt of your request for review. The decision of the independent third party will be final and conclusive upon all persons.

Notice of Denial of Claim Upon Appeal

A written notice of the appeal determination must be provided to you that includes:

- Identification of the claim involved (e.g., date of service, health care provider, claim amount if applicable;
- The specific reason(s) for the denial of claim upon appeal, including (1) the denial code (if any) and its corresponding meaning, (2) a description of the Plan's standard (if any) that was used in denying the claim, and (3) a discussion of the decision;
- A statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- An explanation if the denial was based on an internal rule, guideline, protocol or similar criterion a statement that such rule, guideline, protocol or criterion will be provided free of charge, upon request;
- An explanation if the denial was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

EXTERNAL REVIEW OF CLAIMS

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an

Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

All notices relating to external review sent will contain a notice about the availability of Spanish, Chinese, Tagalog, and Navajo language services. Assistance with filing a claim for external review in Spanish, Chinese, Tagalog, and Navajo is available by calling (844) 552-7805. Notices relating to external review will be provided in Spanish, Chinese, Tagalog, and Navajo upon request.

- SPANISH (Español): Para obtener asistencia en Español, llame al (844)552-7805.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844)552-7805.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码(844) 552-7805.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 552-7805.

Claims Eligible For The External Review Process

Post-Service Claims, in any dollar amount, are eligible for external review by an IRO if:

- The denial of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; or
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment;
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan;
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review; and
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

In general, you may only seek external review after you receive a "final" denial of claim under the Plan's internal appeals process. A "final" denial of claim means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first; or
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must be made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" denial of claim or claim denial following the exhaustion of the Plan's internal claims and appeals process. To begin the standard external review process, contact the Administrator at:

HealthSmart Benefit Solutions, Inc.		
P.O. Box 1014	or	602 Virginia Street, East
Charleston, WV 25324-1014		Charleston, WV 25301
Phone: (844) 552-7805		
Website: healthsmart.com/nysut		

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan

Within five (5) business days of the Administrator's receipt of your request for external review of a standard claim, the Administrator will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided;
- The denial of claim satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed); and
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Administrator will notify you in writing whether:

- Your request is complete and eligible for external review;
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).); or
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period or, if later, within 48 hours after you receive notification that your request is not complete.)

Review Of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims. Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review;
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline;
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination;
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its denial of claim regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review;
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit;
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s); and
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial;
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
- A statement that judicial review may be available to you; and
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

AUTHORIZED REPRESENTATIVE

In making a claim or appeal, you may be represented by an authorized representative. If your representative is not an attorney or court appointed guardian, you must designate the representative by completing and submitting to the Administrator such forms as the Plan requires. If a claimant is unable to provide a completed form, the Administrator will require written proof that the proposed authorized representative has the power of attorney for health care purposes.

Once an authorized representative has been recognized by the Plan, the Plan will direct all information, correspondence, notifications, etc. regarding the claim to the authorized representative rather than to the claimant, unless and until the claimant provides written direction to the Administrator otherwise.

A parent of a minor child is assumed to be the authorized representative of the child for purposes of filing a claim for benefits or appealing a denial of a claim (with limited exceptions).

An authorized representative must be at least 18 years old.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described above) for every issue deemed relevant by the claimant.

No lawsuit may be started more than three (3) years after the end of the year in which a claim was denied. You may not assign, convey, or in any way transfer your right to bring legal action against the Plan or its Trustees to anyone else.

DISCRETIONARY AUTHORITY

The Trustees have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. In addition, in carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or Administrators of the Plan have been delegated and have discretionary authority to interpret the terms of the Plan including, but not limited to, the discretionary authority to resolve ambiguities or inconsistencies in the Plan and to determine the extent to which a person is eligible and entitled to any Plan benefits. Any interpretation or determination made under that discretionary authority

will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Trustees, the Plan Administrator, or their delegates/designees, made in good faith which is not contrary to law is conclusive on all persons affected.

EXCLUSIVE RIGHTS

No individual shall have any right to benefits except as specified in this Plan Document. The Plan will not be bound by any oral representations that are inconsistent with the contents of this Plan Document, and you should not rely on any oral representations that are inconsistent with the terms of this Plan. None of the benefits provided under this Plan are vested.

FACILITY OF PAYMENT

If the Administrator or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan nor the Administrator, nor any other designee of the Administrator, will be required to see to the application of the money so paid.

VI. GENERAL PROVISIONS

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan's Legal Counsel: Meyer, Suozzi, English & Klein, P.C., 1350 Broadway, Suite 1420, P.O. Box 822, New York, NY 10018. Service of legal process may also be made upon any Trustee or upon the Plan Administrator.

PLAN YEAR

The Plan's fiscal records are kept on a calendar year basis beginning on January 1 and ending on December 31.

EMPLOYER IDENTIFICATION NUMBER (EIN)

47-7358956

TYPE OF PLAN, FUNDING AND ADMINISTRATION

This is an Employee Welfare Benefits Plan that provides medical expense benefits. The NYSUT Member Benefits Catastrophe Major Medical Insurance Trust self-funds this group health plan for eligible medical expenses under the Plan. Claims for these benefits are administered by independent claims administrators as listed on the Quick Reference Chart in the front of this document. The funding for the benefits is derived solely from premiums paid by covered participants. The Plan is not insured. Premiums and assets are held in the NYSUT Member Benefits Catastrophe Major Medical Insurance Trust and benefits are paid out of this trust.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator and any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any provider by reason of negligence, by failure to provide care or treatment, or otherwise.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans, like this Plan, maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

The term PHI includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

If the Plan provides health information to the Board of Trustees, the Plan Sponsor, the Board of Trustees agrees:

1. not to use or further disclose PHI other than as permitted or required by the plan documents or as required by law;
2. to ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. not to use or disclose PHI for employment-related actions and decisions;
4. not to use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor;
5. to report to the Plan's designee any use or disclosure of PHI that it becomes aware of that is inconsistent with the uses or disclosures provided for;
6. to make PHI available to an individual in accordance with 45 C.F.R. § 164.524;
7. to make PHI available for amendment and incorporate any PHI amendments in accordance with 45 C.F.R. § 164.526;
8. to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
9. to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
10. to ensure that adequate separation between the Plan and the Plan Sponsor is established as required by 45 C.F.R. §164.504(f)(2)(iii); and
11. if feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, the Plan Sponsor will limit further use and disclosures to those purposes that make the return or destruction infeasible.

A complete description of your rights under HIPAA can be found in the NYSUT Member Benefits Catastrophe Major Medical Insurance Trust's Notice of Privacy Practices, which is available on the Administrators' websites. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

CANCELLATION DURING FIRST 30 DAYS

You may cancel the coverage described in this Plan Document within the first 30 days after initial enrollment. Mail this Plan Document with your written request for cancellation to the Administrator who will promptly refund the premium paid, including any fees.

MISSTATEMENTS

A participant's age, sex or any other data may be misstated. If so, the correct data will be used to determine if coverage is in force. If coverage is in force, the premium and/or benefits will be adjusted according to the facts.

PAYMENT TO A MINOR OR INCOMPETENT

If any beneficiary or payee is a minor or is incompetent to receive payment, the Administrator will pay the beneficiary's or payee's guardian. The Administrator will not be liable for such payment after it is made.

ASSIGNMENT OF BENEFITS

No participant or eligible dependent is permitted to assign any benefits, rights or claims for benefits to any third party, including, but not limited to, a provider or a facility, without the express written consent of the Plan. Accordingly, unless written consent is provided, the Plan will not recognize or accept any assignment of benefits, rights or claims for benefits, or any appeal of a denied claim for benefits. "Benefits, rights or claims for benefits" includes, but is not limited to: (i) a claim, or an appeal of a denied claim, for payment of a benefit under the terms of this Plan Document; (ii) a claim, or an appeal of a denied claim, for benefits or other relief under the terms of this Plan Document or any other plan document or communication; (iii) a breach of fiduciary duty claim under ERISA or common law; (iv) a claim brought under state law; and (v) a claim for penalties assessable under any law or regulation.

SAVINGS CLAUSE

If any provision of this Plan is held to be unlawful, or unlawful as to a particular person or circumstance, such finding shall not adversely affect the application of the other provisions of the Plan as they are described in this Plan Document unless the illegality makes the continued operation of the Plan impossible.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Trust reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

Amendments to the Plan may be made in writing and become effective upon the written approval of the Trust, or on such other date as may be specified in the document amending the Plan.

Allocation and disposition of assets upon termination

In order for the Plan to carry out its obligation to provide the maximum possible benefits to all participants within the limits of its resources, the Trust has the right to take any of the following actions, even if claims that have already accrued are affected:

- Terminate any benefits provided by the Plan;
- Alter or postpone the method of payment of any benefit; or
- Amend or rescind any provision of the Plan.

In addition, the Plan may be terminated by the Trust, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trust will determine the disposition of any assets remaining after all expenses of the Plan and the Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trust will continue in such capacity for the purpose of dissolution of the Plan.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits: This includes the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including, if applicable, insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

The right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under a plan providing group health coverage as a result of a Qualifying Event. You or your dependents will have to pay for such coverage. Review this Plan Document and the documents governing the Plan regarding your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's determination or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds that your claim is frivolous).

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator at 800-626-8101. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, as listed in your telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

VII. DEFINITIONS

Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Assisted Living Facility means a facility that satisfies all of the following:

- Provides 24-hour-per-day care and services sufficient to assist clients with needs that result from the inability to perform activities of daily living;
- Whose residents are not related to the owner or manager of the facility;
- Has a minimum of six residents;
- Uses aides trained or certified to provide needed assistance in accordance with any laws applicable to the provision of such care;
- Provides 24-hour supervision of clients by a trained and awake staff;
- Has formal arrangements for emergency medical care;
- Maintains written records of services provided to each client;
- Provides clients with three meals per day; and
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

Residents in Assisted Living Facilities often live in their own room or apartment within a building or group of buildings and have some or all of their meals together. Social and recreational activities are usually provided. Some of these facilities have health services on site.

Assisted Living Facility does not mean a place, or part of one, that is used mainly for:

- The aged;
- People with substance use/abuse (alcohol/drug) disorders; or
- People with mental, nervous or emotional disorders.

***Basic Plan* as defined in this Plan:**

Basic Plan means any and all of the following Plans in which an eligible participant is enrolled:

- New York State Health Insurance Program's Empire Plan (NYSHIP);
- New York City Health Insurance Program (NYC);
- Plan offered by Member's Employer (e.g., Article 47/Consortium plan, Article 43 plan or employer-sponsored plan) that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act;

- Other group health plan, including the group health plan of a spouse or dependent, that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act; or
- For Medicare-eligible participants, Parts A and B or Part C (Medicare Advantage Plan).

You must have basic prescription drug coverage in order for prescription drug benefits to be payable. If a participant is a Medicare-primary beneficiary, the participant must be enrolled in a Part D Plan or have Creditable prescription drug coverage (as defined by Medicare) through another Basic Plan. No benefits for prescription drugs will be payable under this Plan for individuals who are not enrolled in a prescription drug program.

A Basic Plan does not include:
- An individual Plan either purchased on or off any state/federal Marketplace/Exchange;
- Medicaid;
- A State Children's Health Insurance Plan (CHIP); or
- TRICARE.

Basic Plan **as defined in the Prior Plans** (prior to 1/1/2018) means a plan which:
1. provides benefits or services for, or by reason of, Hospital, surgical, medical, convalescent, or custodial care or treatment through:

    a. group, blanket, franchise, or individual insurance coverage;
    b. group, blanket, franchise, or individual pre-paid plans for:
        - group or individual Hospital service;
        - group or individual medical service;
        - group practice;
        - individual practice; and
        - any other such plans for members of a group;
    c. any plan provided by:
        - labor management trusts;
        - unions;
        - employer organizations;
        - professional organizations; or
        - employee benefit organizations;
    d. a government program or statute, including Medicare, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
    e. medical benefits coverage in group and individual mandatory automobile "no fault" and traditional mandatory automobile "fault" type contracts; and
    f. group, blanket, franchise, or individual long-term care, Nursing Home, home health care, or home health care insurance coverage, or any plan which provides coverage for convalescent or custodial care in a Nursing Home or in a private residence;

    which the benefits in this Plan are intended to supplement; and

2. provides benefits at least as great as the following:
    - Semi-private room and board of $300, per day for 70 days;
    - $25,000 for extra services; and
    - A $5,000 surgical schedule.

The minimum amounts listed above do not apply to plans which primarily provide benefits for long term care, Nursing Home care or home health care.

Benefit Period means the period of time during which benefits are payable. This Plan's Benefit Period is the calendar year and runs from January 1 to December 31.

Convalescent Home means a licensed institution that maintains a daily record, which is available to the Administrator, on the condition of and the services to each participant, and that has on its premises:

- Organized facilities to care for and treat its patients;
- A staff of Physicians to supervise such care and treatment; and
- A Registered Nurse (RN) on duty at all times.

Convalescent Home does not mean a place, or part of one, which is used mainly for:

- The aged;
- People with substance use/abuse (alcohol/drug) disorders; or
- People with mental, nervous or emotional disorders.

"Nursing Homes" are considered Convalescent Homes or Custodial Care Facilities for purposes of paying claims.

Covered Charge(s) as referred to in Section IV - *Benefits, Exclusions and Limitations*.

Critical Illness means a heart attack, stroke, terminal illness, cancer, quadriplegia or an illness requiring coronary bypass surgery or a major organ transplant.

Currently Employed for purposes of the Plan's eligibility criteria (see Section III - *Eligibility*) means an individual employed by any employer as an employee. A person whose employment by the pertinent employer terminates shall cease to be "currently employed" within the meaning of the Plan for purposes of the Plan's eligibility criteria.

Custodial Care Facility means a licensed facility which provides care made up of services and supplies which a covered participant needs for assistance in the activities of daily living. Such facility must maintain a daily record, which is available to the Administrator, on the condition of and the services to each patient.

Custodial Care Facility does not mean a place, or part of one, which is used mainly for:

- The aged;
- People with substance use/abuse (alcohol/drug) disorders; or
- People with mental, nervous or emotional disorders.

"Nursing Homes" are considered Convalescent Homes or Custodial Care Facilities for purposes of paying claims.

Deductible means the aggregate amount for certain Covered Charges that is a participant's responsibility each calendar year before this Plan will begin to pay for most Covered Charges.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Labor Act (EMTALA), including:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions; or
- Serious dysfunction of any bodily organ or part of such person.

For example, an Emergency Medical Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; and
- Convulsions.

Emergency Services means, with respect to an Emergency Medical Condition **--** (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency Medical Condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination or treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

Essential Health Benefits means health benefits as defined under federal health law to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Under this Plan the following are not considered to be Essential Health Benefits: convalescent/custodial care in a Convalescent

Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility; and Private Duty Nursing.

Experimental or Investigational means any services, supplies (including Prescription Drugs), or procedures that are experimental treatments or investigational in nature or are not within the standards of generally accepted medical practice. A drug, device, or medical treatment or procedure is considered Experimental or Investigational if: A) It is a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; B) Reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or C) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure. This Plan does not cover Experimental Treatments.

Home Health Care Agency means an agency or organization that provides a program of home health care and meets all of the following requirements:

- Has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or RN to the home;
- Has a full-time administrator;
- Is run according to rules established by a group of professional health care providers including Physicians and RNs;
- Maintains written clinical records of services provided to all patients;
- Its staff includes at least one RN or it has nursing care by an RN available;
- Its employees are bonded;
- Maintains malpractice insurance coverage; and
- Is Medicare-certified or licensed or certified by a state department of health or other state regulatory authority responsible for licensing or certifying Home Health Care Agencies.

NOTE: Nurse Registries fall under this definition.

Hospice means an entity licensed, approved or authorized to provide inpatient and/or outpatient medical relief of pain and supportive care to terminally ill persons. Such entity must have on its premises:

- Organized facilities to care for and treat terminally ill persons; and
- A paid staff of medical professionals to supervise such care and treatment.

A Physician must certify that the terminally ill person has a life expectancy of six (6) months or less.

Hospital means a class of health care institutions that is a public or private facility or institution, licensed and operating as a Hospital in accordance with the laws of the appropriate legally authorized agency, which:

- Provides care and treatment by Physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises;
- Provides diagnosis and treatment on an inpatient basis for compensation; and
- Is approved by Medicare as a Hospital.

The facility may also be accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). A Hospital may include facilities for mental health treatment that are licensed and operated according to law.

Any portion of a Hospital used as an ambulatory surgical/outpatient surgery facility, birth (or birthing) center, Hospice, Skilled Nursing Facility, inpatient rehabilitation facility, Subacute Care Facility/long term acute care facility or other residential treatment facility or place for rest, custodial care, or facility for the aged will not be regarded as a Hospital for any purpose related to this Plan.

In-Network means services or supplies provided by a Physician, provider or facility that is a member of a Basic Plan's Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), or Health Maintenance Organization (HMO) or, when Medicare is the Basic Plan, by a provider that is enrolled in Medicare.

Intensive Outpatient Program (IOP) is one that provides treatment in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six (6) hours per week. Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day. The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60 minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health provider for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent. To be payable by this Plan, a facility must be licensed as an IOP (licensure requirements for an IOP may vary by state).

Life Event means a qualifying event which would allow for an eligible dependent to be added to the existing coverage (e.g., marriage, birth, etc.).

Medically Necessary/Medical Necessity/Necessary Care or Treatment means care, treatment, services or supplies which are:

- Provided by or under the direction of a Physician or other duly licensed provider who is authorized to provide or prescribe it;
- Determined by the Administrator or its designee to be necessary in terms of generally accepted American medical standards; and

- Is determined by the Administrator or its designee to meet all of the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
  - It is not provided solely for the convenience of the patient, Physician, Hospital, provider or facility; and
  - It is an "appropriate" service or supply given the patient's circumstances and condition; and
  - It is a "cost-efficient" supply or level of service that can be safely provided to the patient; and
  - It is safe and effective for the illness or injury for which it is used.
    - A medical service or supply will be considered to be "appropriate" if:
      - It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition
      - It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
    - A medical service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to another facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or other more costly facility.

The non-availability of a bed in another facility, or the non-availability of a provider to provide medical services will not result in a determination that continued confinement in a Hospital or other facility is Medically Necessary.

A medical service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a provider or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any provider or facility.

Medicare means Parts A B, C and D of the medical care and prescription drug benefits provided by Title XVIII of the Social Security Act of 1965.

Non-Job Related Injury or Sickness means conditions for which a person is not entitled to benefits from a workers' compensation or similar law.

Nursing Homes are considered Convalescent Homes or Custodial Care Facilities for purposes of paying claims.

NYSUT Member means an in-service or retired Member of NYSUT, a Service Fee Payer to NYSUT, or an Associate Member (Continuing NYSUT Member Benefits Coverage category) of NYSUT who was covered under the Prior Plans on December 31, 2017 based on Associate Member status.

Out-of-Network means services or supplies provided by a Physician, provider or facility that is not a member of a Basic Plan's Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), or Health Maintenance Organization (HMO) or, when Medicare is the Basic Plan, by a provider that is not enrolled in Medicare.

Partial Day Care/Partial Hospitalization means treatment of mental, nervous, or emotional disorders and substance abuse at a Hospital for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a Hospital/facility. To be payable by this Plan, a facility must be licensed to provide Partial Day Care/Hospitalization (licensure requirements for this residential level of care may vary by state).

Physician or Provider means:

- a medical practitioner licensed to provide medical services and perform general surgery;
- any other practitioner whose services, by law of the state where such services are performed, must be covered by the Plan; or
- to the extent required by the Affordable Care Act regulations, a provider includes a health care provider acting within the scope of the provider's license or certification under applicable state law, as is performing covered services under this Plan.

Each such person must be licensed in the state where the person performs the service and must act within the scope of that license. The physician or provider must also be certified and/or registered if required by such state.

Prior Plan means 1. NYSUT Member Benefits Trust's plan in effect on December 31, 2013, group policy number E-170,129, underwritten by The United States Life Insurance Company in the City of New York; 2. the NYSUT Member Benefits Trust-sponsored Plan in effect January 1, 2014 to August 31, 2015, group policy number CMM1-001; and 3. The NYSUT Member Benefits Catastrophe Major Medical Insurance Trust- sponsored Plan in effect September 1, 2015 to December 31, 2017, group policy number CMM1-001.

Residential Treatment Program/Facility/Care is a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state). A Hospital may include inpatient acute care facilities for mental health and substance use disorder treatment that are licensed and operated according to law.

Skilled Nursing Facility (SNF) is a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to individuals who require medical or nursing care and that rehabilitates injured, disabled or sick individuals, and that meets all of the following requirements:

- It is accredited by The Joint Commission (TJC) on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility;
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Services of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician;
- It provides services under the supervision of Physicians;
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one licensed Registered Nurse on duty at all times;
- It maintains a daily medical record of each patient who is under the care of a licensed Physician;
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of individuals who are aged, blind, deaf, or suffering from tuberculosis; and
- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Skilled Nursing Services are services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Subacute Care Facility is a public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide subacute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets all of the following requirements:

- It is accredited by The Joint Commission (TJC) on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility;
- It maintains on its premises all facilities necessary for medical care and treatment;
- It provides services under the supervision of Physicians;
- It provides nursing services by or under the supervision of a licensed Registered Nurse;
- It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of individuals who are aged, blind, deaf, or suffering from tuberculosis; and
- It is not a hotel or motel.

Subacute Care Facility is sometimes referred to as a specialty Hospital, post-acute care, or long-term acute care (LTAC) facility.

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