SUMMARY PLAN DESCRIPTION
FOR

THE RESEARCH FOUNDATION FOR THE STATE UNIVERSITY OF NEW YORK
GRADUATE STUDENT EMPLOYEE HEALTH PLAN

Restatement August 15, 2013

CLAIMS ADMINISTRATORS:

MEDICAL BENEFITS
POMCO
PO Box 6329
Syracuse, New York 13217
1.866.317.2098
Website: www.MyPomco.com

PRESCRIPTION DRUG BENEFITS
Express Scripts
P.O. Box 14711
Lexington, KY 40512
1.800.818.6632
Website: www.express-scripts.com

After you log onto the website you will be able to view covered services under your benefit plan; locate participating providers nationwide; view a summary of paid claims; print claim forms; and link to other health and wellness websites.

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INTRODUCTION

This document is a description of The Research Foundation for the State University of New York Graduate Student Employee Health Plan (the Plan). No oral interpretations can change this Plan.

This handbook updates and replaces previous publications showing coverage for the self-funded The Research Foundation for the State University of New York Graduate Student Employee Health Plan. It is a restatement of Plan benefits and includes Plan changes to August 15, 2013. Benefits shown are for Covered Charges incurred on or after August 15, 2013. For previous Plan Years, see previous publications or contact the office that handles graduate student Employee or Fellow benefits at the location where you are a graduate student Employee or Fellow.

This handbook describes the health Plan (Medical Benefits and Prescription Drug Benefits) for graduate student Employees and Fellows of The Research Foundation for SUNY. For information on other benefits such as dental and vision care, disability protection, and international travel assistance, please refer to the Research Foundation for SUNY website at www.rfsuny.org and click on Working at the RF>Your RF Benefits>Graduate Student Employees. The site includes a Graduate Student Employee Benefits Handbook which outlines all of your benefits.

Coverage under the Plan will take effect for an eligible Employee or Fellow and designated dependents when the Employee or Fellow and such dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, Medical Necessity, failure to timely file claims, or lack of coverage.

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Members, and their covered dependents and is divided into the following parts:

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

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

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

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges. **It is important to read this section about approval needed for some services to be fully covered.**

Defined Terms. Defines those Plan terms that have a specific meaning. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

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

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

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

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

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

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Employee graduate students who meet the eligibility requirements of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a SUNY graduate student employed by the Research Foundation for SUNY in a RF student title, whose work coordinates with education and training leading to the fulfillment of academic requirements, and receiving an annual salary of at least $4,122.00 ($158.54 bi-weekly) for Plan Year 8/15/13 – 8/14/14; and paid bi-weekly through the Research Foundation for SUNY payroll system, and appointed to a position for which it is anticipated that funds will be available for an appointment period of at least one semester, and Employed in active pay status (graduate student Employees may be eligible for coverage during summer period even if not in active pay status).

(2) is an international SUNY graduate student holding an F-visa or J-visa, who qualifies under the requirements of number (1) above. F-visa, and J-visa holders must also purchase medical evacuation and repatriation insurance through the SUNY Health Plan for International Students.

You may continue coverage during the summer period, even if you are not actively a graduate student Employee, under the following circumstances:

(1) You were covered by the Plan throughout the preceding semester.

(2) The Operations Manager for the Research Foundation for SUNY at your campus certifies that you are expected to be re-appointed in the fall.

(3) You pre-pay the entire Employee share of the premium for the summer period.

Eligible Classes of Fellows. A scholar who is receiving non-wage payments from the Research Foundation for SUNY in support of academic study or fellow-initiated research and meets the eligibility requirements of the Research Foundation for SUNY. The Fellow must receive an annual stipend of at least $4,122.00 for Plan Year 8/15/13 -8/14/14 to be eligible.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) **A covered Member's spouse.** The term "spouse" shall mean the person recognized as the covered Member's:

(a) husband or wife of the opposite gender under the laws of the state where the covered Member lives; or

(b) husband or wife of the same gender when there has been a marriage which is legally valid in the jurisdiction in which it occurred and the couple possesses a valid marriage license or certificate from that jurisdiction.

The Plan Administrator may require documentation proving a legal marital relationship.

(2) **A covered Member’s Domestic Partner.** The term “Domestic Partner” shall mean a person who is the Member’s sole spousal equivalent and is responsible with the Member for each

other's welfare. Contact your Campus Benefits office for Domestic Partner eligibility criteria. A Domestic Partner relationship must be demonstrated by:

(a) registration of the Domestic Partnership or signed affidavit;

(b) proof of cohabitation; and

(c) evidence of two or more of the following: **1)** a joint bank account, credit or charge card; **2)** joint obligation on a loan; **3)** status as authorized signatory on the partner's bank account, credit card or charge card; **4)** joint ownership or holding of investments; **5)** joint ownership of residence or ownership of real estate other than residence; **6)** listing of both partners as tenants on the lease of the shared residence; **7)** shared rental payments of residence; **8)** listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; **9)** a common household and shared household expenses; **10)** shared household budget for purposes of receiving government benefits; **11)** status of one as representative payee for the others government benefits; **12)** joint ownership of major items of property; **13)** joint ownership of a motor vehicle; **14)** joint responsibility for child care; **15)** shared child-care expenses; **16)** execution of wills naming each other as executer and/or beneficiary; **17)** designation as beneficiary under the other's life insurance policy or the others retirement benefits account; **18)** mutual grant of durable power of attorney; **19)** mutual grant of authority to make health care decisions; **20)** affidavit by creditor or other individual able to testify to partners' financial interdependence; or **21)** other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

(3) A covered Member's Dependent children.

(a) Children from birth to the limiting age of 26 years who are the biological children of the Member, adopted children of the Member, children placed with a covered Member in anticipation of adoption or Foster Children without regard to student status, marital status, financial dependency or residency status with the Member..

Step-children (same-gender spouse and opposite-gender spouse) may also be included as long as a biological parent remains married to the Member.

Children of the Domestic Partner may also be included as long as a biological parent qualifies as a covered Domestic Partner with the Member.

If a covered Member is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Member in anticipation of adoption" refers to a child whom the Member intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Member of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(c) A covered Dependent child who reaches the limiting age and is Totally Disabled must be: **1)** unmarried, **2)** Incapable of self-sustaining employment by reason of mental Illness, developmental disability, mental retardation or physical handicap; and, **3)** Primarily dependent upon the covered Member for support and maintenance. Proof of such incapacity and dependency shall be furnished by the Member within 31 days of the child's attainment of the limiting age or at the time of your initial enrollment if the child is the limiting age or older at that time. Subsequently, such proof must be submitted annually following the child's attainment of the limiting age. If a claim is denied under the Plan because the child attained the limiting age for Dependent children, the burden is on the covered Member to establish the child is and continues to be handicapped as defined by subsection **1)**, **2)** and **3)**. Coverage ends on the date the Dependent child no longer meets all three of the criteria met in the above subsections.

The phrase "primarily dependent upon" shall mean dependent upon the covered Member for support and maintenance as defined by the Internal Revenue Code and the covered Member must declare the child as an income tax deduction.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records (if applicable) or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Member's home, but who are not eligible as defined; or divorced former spouse of the Member; or any person who is covered under the Plan as a Member.

If a person covered under this Plan changes status from Member to Dependent or Dependent to Member, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Members, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of a Member will become eligible for dependent coverage on the first day that the Member is eligible for Member coverage and the family member satisfies the requirements for dependent coverage.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Research Foundation for the State University of New York Graduate Student Employee Health Plan shares the cost of Employee and dependent coverage under this Plan with the covered Employees. Eligible and enrolled post-doctoral Fellows and their dependents must pay the full Plan premium.

The level of any Member contributions is set by the Plan Administrator and for Employees will be paid through the Flexible Benefits Plan of the Research Foundation for SUNY, reducing the Employee's taxable income by the amount of the contribution, as permitted under Section 125 of the Internal Revenue Code. Fellows are not eligible for participation in the Research Foundation's Flexible Benefits Plan. The Plan Administrator reserves the right to change the level of Member contributions.

ENROLLMENT

Enrollment Requirements. Enrollment in the Plan is not automatic. You are required to enroll yourself and your Dependents. A Member must enroll for Individual, Individual + 1, or family coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization, if applicable. Plan participation costs are based on the type of coverage you choose. It is your responsibility to apply for any enrollment changes. Plan coverage options are as follows:

(1) **Individual Coverage.** Employee only or one eligible COBRA participant is enrolled. Coverage is provided for that person only. It does not cover other Dependents, even if they are eligible for coverage under the Plan.

(2) **Individual +1 Coverage.** Employee and one eligible Dependent are enrolled. It also includes an ex-spouse/domestic partner or survivor spouse/domestic partner and his or her one eligible Dependent under COBRA continuation of coverage. Coverage provides benefits for the eligible enrolled Employee or ex-spouse/domestic partner or survivor spouse/domestic partner and for his or her one eligible Dependent.

(3) **Family Coverage.** Employee and two or more eligible Dependents are enrolled. It also includes an ex-spouse or survivor spouse and two or more of his or her eligible Dependents under COBRA continuation of coverage. Coverage provides benefits for the eligible enrolled Employee, or ex-spouse/domestic partner or survivor spouse/domestic partner and for his or her eligible enrolled Dependents.

If the covered Member already has dependent coverage, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children. A newborn child of a covered Member who has dependent coverage is not automatically enrolled in this Plan.

Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

TIMELY ENROLLMENT

Timely Enrollment. The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 45 days after the Enrollee initially becomes eligible for the coverage, or as specified under the Special Enrollment Period qualifiers.

Open Enrollment. Each year there is an open enrollment period from August 15th through September 30th. During this time you may enroll if you have not previously done so, or you may drop your coverage or change your individual, individual + 1, or family coverage without a qualifying event.

Enrollment forms are available in the office that handles graduate student Employee or Fellow benefits at the location where you are a graduate student Employee or Fellow. These applications **Must** be returned to the office that handles graduate student Employee or Fellow benefits. **Do not send them directly to POMCO.**

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Exception: see "**Late Enrollment**".

(1) **Individuals losing other coverage.** A Member or dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

- **(a)** The Member or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- **(b)** If required by the Plan Administrator, the Member stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- **(c)** The coverage of the Member or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
- **(d)** The Member or dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
- **(e)** For purposes of these rules, a loss of eligibility occurs if:
  - **(i)** The Member or dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.
  - **(ii)** The Member or dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees). .
  - **(iii)** The Member or dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
  - **(iv)** The Member or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
  - **(v)** The Member or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Member or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Dependent beneficiaries**. If:

(a) The Member is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a dependent of the Member through marriage, birth, adoption or placement for adoption, or within 30 days of a previously un-enrolled dependent's arrival in the United States.

Then the dependent (and if not otherwise enrolled, the Member) may be enrolled under this Plan as a covered dependent of the covered Member. In the case of the birth or adoption of a child, the spouse of the covered Member may be enrolled as a dependent of the covered Member if the spouse is otherwise eligible for coverage.

The dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the dependent enrolled in the Special Enrollment Period will be effective:

(1) in the case of marriage, the date of marriage;

(2) in the case of a dependent's birth, as of the date of birth; or

(3) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption;

(4) in the case of dependents arrival in the United States, the date of arrival.

(3) **Late Enrollment.** If you do not enroll within 45 days of becoming eligible, there will be a 30 day waiting period before coverage begins.

(4) **Medicaid and State Child Health Insurance Programs.** Members and dependents who are eligible for, but not enrolled, in this Plan may also enroll in this Plan when:

(a) the Member or dependent loses eligibility under Medicaid or the state's Children's Health Insurance Program (CHIP), and the Member requests coverage under this Plan within a Special Enrollment Period of 60 days after the date of termination of coverage; or

(b) the Member or dependent becomes eligible for premium assistance under Medicaid or the state's Children's Health Insurance Program (CHIP) to subsidize the cost of coverage in this Plan, and the Member requests coverage under this Plan within a Special Enrollment Period of 60 days after eligibility for a premium assistance subsidy is determined.

EFFECTIVE DATE

Effective Date of Member Coverage. A Member will be covered under this Plan as of the first day that the Member satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Member Requirement.

(3) The Enrollment Requirements of the Plan.

Active Member Requirement. A Member must be an Active Member (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Member is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Claims Administrator for further details about the Certificate of Creditable Coverage.

When Member Coverage Terminates. Member coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Member may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) Twenty-eight days after the day the covered graduate student Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.)

(3) The day the covered Fellow ceases to be in one of the Eligible Classes. This includes death or termination of the Fellowship. (See the Continuation Coverage Rights under COBRA.)

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) The date you make a fraudulent claim for benefits under this Plan.

When Dependent Coverage Terminates. A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or dependent coverage under the Plan is terminated.

(2) The date that the Member's coverage under the Plan terminates for any reason including death. (See Survivor Spouse; Continuation Coverage Rights under COBRA.)

(3) The date a covered spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)

(4) On the first date that a dependent child ceases to be a dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

CONTINUATION DURING FAMILY AND MEDICAL LEAVE

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Member and his or her covered dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

REHIRING A TERMINATED MEMBER

A terminated Member who is rehired as an Employee or reinstated as a Fellow will be treated as a new hire or new Fellowship and be required to satisfy all Eligibility and Enrollment requirements.

EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(2) The 24-month period beginning on the date on which the person's absence begins; or

(3) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect to this coverage or obtain more detailed information, contact the Plan Administrator. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their dependents. Only the Employee has election rights. Dependents do not have any independent rights to elect USERRA health plan continuation.

SCHEDULE OF BENEFITS

Verification of Eligibility 1.866.317.2098

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

COMPREHENSIVE MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual, Reasonable, and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified if this Plan is primary.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or surgical services are provided:
Hospitalizations
Substance Use Disorder/Mental Disorder inpatient admissions
Home Health Care
Chemotherapy/Infusion (I.V.) therapy
Transplants
Dialysis

Please see the Cost Management section in this booklet for details.

NETWORK PROVIDER ORGANIZATIONS

The Plan is a plan which contains two Network Provider Organizations. Eligible services by Providers in either network will be covered as In-Network.

PPO name:	POMCO/PHCS/Multiplan MagnaCare Network may also be utilized in addition to the POMCO/PHCS/Multiplan Networks Covered Persons enrolled at the campus of the University Center of Buffalo, University College at Buffalo, Stony Brook, and Farmingdale.
Address:	PO Box 6329 Syracuse, NY 13217
Telephone:	1.866.317.2098
Web site:	www.MyPOMCO.com (log on, then click on “Find a Physician or Hospital”)

Check your identification card to confirm what Networks apply to you.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. The Plan agrees to reimburse the Provider directly for covered services.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request.

Under the following circumstances, the higher In-Network payment will be made for certain out-of-network services:

> If a Covered Person is not able to locate an In-Network Provider for Preventive Care Services, items or services there will be no cost sharing for the Out-of-Network Provider's charges.

OUT OF COUNTRY CARE

This Plan will provide benefits for covered expenses incurred outside the USA. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where services is rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the Enrollee directly. **True Medical Emergencies, in Hospital facilities (inpatient and Outpatient), are covered at the In-Network level.**

OUT OF AREA CARE

This Plan will provide benefits for covered expenses incurred outside the Plan area where you are Employed. Covered Persons can receive an In-Network benefit through PHCS/Multiplan or MagnaCare (if you are enrolled at a campus that includes this Network) when traveling out of the area. **True Medical Emergencies, in a Hospital facility (inpatient and Outpatient), are covered at the In-Network level.**

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Plan ceases on the date coverage terminates (see "Termination of Coverage"). However, if a Covered Person is Hospital-Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the termination Date.

The total payments made in respect to the Covered Person for such condition both before and after the termination date will never exceed the Maximum Benefit.

If the Covered Person is also a Covered Person under the succeeding policy issued by this Plan; this "Extension of benefits" provision will not apply.

THE STUDENT HEALTH CENTER

Most SUNY campuses have Student Health Centers which provide medical services, including appointments or walk-in service for routine primary care. Some also provide urgent care and limited specialty services. Students are urged to use the services of the campus Student Health Center when appropriate, and to verify the levels of care that can be obtained at the Student Health Center on the campus where the student is employed. On some campuses, the Student Health Center bills patients for services not covered under the campus mandatory health fee. Some of these services may be covered by the GSEHP. Contact your customer service department for details. Covered dependents of enrolled student Members do not have access to a campus Student Health Center. Covered spouses, Domestic Partners and dependent children enrolled in the Plan have the option to use a PPO Provider but are not

required to use one. However, using a PPO Provider will result in a savings to the insured.

***Reference to the Student Health Center in this document will apply to Fellows only if they are registered students.**

DEDUCTIBLES/COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. This Plan has additional benefit deductibles that are separate from the Plan Year deductible. Please refer to the Schedule of Benefits below for details. Each August 15th, a new deductible amount is required.

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments.

COORDINATION OF BENEFITS

When services and supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules, all benefits will still apply. All Copayments will be waived.

ALLOWED CHARGE(S)

Allowed Charges is the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for covered medical services rendered and billed by a covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered service, please refer to the sections entitled **Comprehensive Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Plan Year Deductible	Does not apply to most services. See individual Plan features for details and exceptions when Out-of-Network deductible will apply.	$100 per individual, no other deductible applies. See individual Plan features for details, and exceptions.
Benefit Deductible for Therapy Services per Plan Year (Physical Therapy, Occupational Therapy, and Chiropractic Services)	Does not apply.	$100 per individual, no other deductible applies. See individual Plan features for details.
Benefit Deductible per Inpatient Admission	Does not apply.	$200 per Admission, no other deductible applies. Inpatient benefit deductible does not apply to Plan Year or therapy services deductible.
Network Copayment per Inpatient Admission	$200 per Admission, no other Copayment applies.	Does not apply.
Benefit Copayment	**Emergency Room Visit: $**25 Copayment per visit (facility and professional charges combined). **Ambulance:** $15 Copayment	
Network Copayment (includes office visits)	$10 Copayment per Provider per day. See individual Plan features for exceptions and details	Does not apply.
Percentage Coinsurance	The Plan pays 100% of the Allowed Charges for most covered services and supplies. See individual Plan features for details and exceptions.	The Plan pays 80% of Allowed Charges for covered services and supplies. See individual Plan features for details and exceptions.
Plan Year Maximums	Unlimited	
Cost Management Services Program/Pre-notification	This mandatory program requests a phone call within five working days before the Covered Person is admitted to a Hospital or before a surgical procedure is scheduled to be performed in an inpatient setting or within 2 working days after if the admission was an emergency. Please contact the POMCO Cost Management Program toll-free at 1.866.317.2098. A benefit reduction of 50% of Allowed Charges after applicable deductible or Copayment will be applied for non-compliance with this requirement. Precertification is not a guarantee that benefits will be paid.	

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Service Type	In-Network Benefits	Out-of-Network Benefits
Acupuncture	Not a Benefit	Not a Benefit
Allergy Injections	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Allergy Serum	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Allergy Testing	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Ambulance	$15 Benefit Copayment then 100% of Allowed Charges	$15 Benefit Copayment then 100% of Allowed Charges. Plan Year deductible does not apply
	Professional and volunteer ambulance, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Anesthesia	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
	Excludes services covered under the Infertility provisions of the Plan. Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.	
Biofeedback	Not a Benefit	Not a Benefit
Blood and Blood Product Services	**Per service type rendered.** Autologous and directed donations excluded.	
Cardiac Rehabilitation	Not a Benefit	Not a Benefit
Chemotherapy ☎		
• **Freestanding Facility**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Physician Office**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Chiropractic Care	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to therapy deductible
	Medically Necessary treatment only. **No Maintenance Care**.	
Consultation		
• **Inpatient Consultation**	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient/Office**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Second Opinion**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Second Opinion Consultation for Cancer Diagnosis** • Written referral from Primary Physician	$10 Network Copayment then 100% of Allowed Charges	$10 Copayment then 100% of Allowed Charges; not subject to deductible
• No written referral	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible.
	Covered medical expenses will be paid under the inpatient benefit or under the Outpatient benefit for Physicians visits, but not both on the same day.	
Dental Care, Limited	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Services must be performed by a Physician; and made necessary by Injury to Sound Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Treatment must be received within 12 months of the Injury.	
Diabetic Education	$10 Network Copayment then 100% of Allowed Charge	80% of Allowed Charges subject to Plan Year deductible
Diabetic Supplies/Equipment	100% of Allowed Charges	100% of Allowed Charges subject Plan Year to deductible
	Not a separate benefit. Medically Necessary glucometers and insulin pumps are covered under the “Durable Medical Equipment” benefit. Syringes are covered under the “Medical Supplies (home use)” benefit or “Prescription Drug Benefits”. Additional diabetic supplies are covered under your “Prescription Drug Benefits”.	
Diagnostic Testing • **Independent/Free-standing Laboratory**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Laboratory**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Machine Testing**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient Hospital**	100% of Allowed Charges. **Note:** $15 Network Copayment applies if services provided on a different date or different location than office or clinic visit.	80% of Allowed Charges subject to Plan Year deductible
• **Professional Interpretation**	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
• **X-ray**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Excludes services covered under the “Preventive Care” and Infertility provisions of the Plan.	

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Service Type	In-Network Benefits	Out-of-Network Benefits
Dialysis ☎ • **Freestanding Facility**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Home**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Physician Office**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Durable Medical Equipment/ Oxygen	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Prescription required. The rental is only allowed up to the purchase price. Repair and maintenance allowed. No replacement or duplication allowed. See Preventive Care provisions for coverage of Breast Pumps under the Plan.	
Food Products (Aminoacidopathies Formula, Enteral Formulas, Modified Solid Food Products)	80% of Allowed Charges subject to Plan Year deductible	80% of Allowed Charges subject to Plan Year deductible
	$2,500 Benefit Maximum per Plan Year for all nutritional supplements for phenylketonuria and related disorders, and enteral formulas and modified food products combined. **Benefit maximums apply to Network and Out-of-Network services combined.**	
Foot Care and Podiatry Services	**Per service type.** No routine services.	
Hearing Aid/Exam	Not a Benefit	Not a Benefit
Home Health Care ☎	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
	365 visits maximum per Plan Year, in lieu of Hospitalization. Prior Hospitalization is required. **Benefit maximums apply to Network and Out-of-Network services combined.**	
Hospice Care	100% of Allowed Charges.	100% of Allowed Charges. Deductible does not apply.
	Limited to 210 days per Plan Year (day count starts with 1st approved visit).Bereavement counseling is limited to 5 visits per family (before or after the patient's death). **Benefit maximums apply to Network and Out-of-Network services combined.**	
Hospital Facility • **Inpatient Hospital** ☎	$200 Network Copayment per admission then 100% of Allowed Charges, no other Copayment applies	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies
	Maternity is covered the same as any other Illness. Routine nursery care is covered. A separate $200 deductible or Copayment applies for newborn inpatient facility charges. Inpatient Mental Disorder and Substance Use Disorder care is shown below.	

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Outpatient Hospital**		
• **Clinic**	$15 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• **Diagnostic Testing**	See Diagnostic Testing	See Diagnostic Testing
• **Emergency Room for Emergency Condition and Related Charges**	100% of Allowed Charges	
	$25 Benefit Copayment per visit. Benefit Copayment waived if $25 Benefit Copayment was already applied to the Emergency Room Physician's fee. **Emergency Room expenses incurred will be paid only for Sickness or Injury which fulfills the definition of "Medical Emergency". These expenses will not be paid for minor Injuries or minor Sicknesses.**	
• **Emergency Room for non-Emergency Condition and Related Charges**	Not a benefit	Not a benefit
• **Outpatient Surgical Center**	$15 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Does not include services covered under the Preventive Care provisions of the Plan.	
• **Other Outpatient Hospital Services and Supplies**	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
Impotency Treatment	Not a benefit	Not a benefit
Infertility Services	Not a benefit	Not a benefit
In-Hospital/Facility Physician's Care	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
	Limit one visit per Provider per day per specialty and does not apply to surgery related care. Covered medical expenses will be paid under the inpatient benefit or under the Outpatient benefit for Physicians visits, but not both on the same day.	
Intercollegiate Sports	100% of Allowed Charges subject to Plan Year deductible	80% of Allowed Charges subject to Plan Year deductible
	$500 Benefit maximum for each Injury per Plan Year. No benefit available under any other benefits once exhausted.	
IV (Infusion) Therapy ☎	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
Massage Therapy	Not a Benefit	Not a Benefit

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Service Type	In-Network Benefits	Out-of-Network Benefits
Maternity Care • **Inpatient Hospital** ☎	$200 Network Copayment per admission then 100% of Allowed Charges, no other Copayment applies	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies
	Maternity is covered the same as any other Illness. Routine nursery care is covered. A separate $200 deductible or Copayment applies for newborn inpatient facility charges.	
• **Physician Charge**	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible
	Benefits will be paid for: • parent education; • assistance and training in breast or bottle feeding; and • the performance of any necessary maternal clinical assessments. In the event the mother chooses an earlier discharge, at least one home visit will be available to the Mother, and not subject to any deductibles, Coinsurance, or Copayments. The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) shall be conducted within 24 hours following: • discharge from the Hospital; or • the mother's request; whichever is later. Except for the one home visit after early discharge, all benefits shall be subject to all deductible and Coinsurance limits under the Plan. Midwife covered same as Doctor. Plan will pay one but not both. See additional coverage under the Preventive Care provisions of the Plan.	
Medical/Surgical Supplies	Not a Benefit unless part of an approved Home Health Care, Hospice, Chemotherapy or surgery service. Diabetic Supplies/ Equipment covered under a separate benefit. Please refer to Schedule of Benefits for any specific limits.	
Mental Disorder Treatment • **Inpatient** ☎ • General Hospital or Private Proprietary Psychiatric Facility • Partial Hospitalization	$200 Network Copayment per Admission then 100% of Allowed Charges, no other Copayment applies	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies
• **Inpatient, Physician Charge**	100% of Allowed Charges.	80% of Allowed Charges subject to Plan Year deductible

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Outpatient/Office**	$10 Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to the Plan Year deductible
	Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license; and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, physician's corporation or clinic for the services of a similarly licensed Provider will be covered.	
• **Psychological Testing**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Mental Disorder Treatment or Substance Use Disorder ☎ • **Residential Treatment Center** • **Group Home** • **Halfway House**	$200 Network Copayment per Admission then 80% of Allowed Charges, no other Copayment applies.	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies
	Limited to 30 days of Inpatient Care per Covered Person per Plan Year in a Residential Treatment Center, Group Home or Halfway House (in an approved facility) for an approved plan of care. The 30 day limit is for Mental Disorders and Substance Use Disorders combined.	
Newborn Care • **Circumcision**	100% of Allowed Charges	100% of Allowed Charges. Deductible does not apply.
• **Hospital**	100% of Allowed Charges	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies A separate $200 deductible or Copayment applies for maternity inpatient facility charges.
• **Physician**	100% of Allowed Charges	100% of Allowed Charges. Deductible does not apply.
Nursing, Private Duty • **Inpatient**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Licensed Physician orders required.	
Obesity, Morbid Treatment	Not a Benefit	Not a Benefit
Occupational Therapy • **Freestanding Facility**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
• **Outpatient Hospital**	$15 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Physician Office**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
Orthotics	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Prescription required. Rental only allowed to purchase price. Repair and maintenance allowed. No replacement or duplication allowed.	
Physical Rehabilitation Facility, Inpatient	Not a Benefit	Not a Benefit
Physical Therapy		
• **Freestanding Facility**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
• **Outpatient Hospital**	$15 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
• **Physician Office**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
	Pre-authorization required.	
Physician Care		
• **Emergency Room**		
• Emergency Condition and Related Charges	$25 Copayment per visit then 100% of Allowed Charges	
	Copayment waived if $25 Copayment was already applied to the emergency room facility charge. **Emergency Room expenses incurred will be paid only for Sickness or Injury which fulfills the definition of "Medical Emergency" These expenses will not be paid for minor Injuries or minor Sicknesses.**	
• Non-Emergency Condition and Related Charges	Not a Benefit	Not a Benefit
• **Home, Office, Clinic or Elsewhere**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Covered medical expenses will be paid under the inpatient benefit or under the Outpatient benefit for Physicians visits, but not both on the same day.	
• **Urgent Care**	See Urgent Care Facility	See Urgent Care Facility
Physiotherapy, Inpatient Acute Care Hospital ☎	$200 Network Copayment per Admission then 100% of Allowed Charges, no other Copayment applies.	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies.

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Service Type	In-Network Benefits	Out-of-Network Benefits
Preadmission Testing	100% of Allowed Charges	100% of Allowed Charges. Deductible does not apply.
	Must be: • Performed on an outpatient basis within seven days before a scheduled Hospital confinement; • Your Physician ordered the tests; and • Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs • **If This Plan is Primary**	Benefits are only available through Express Scripts Prescription Benefit Plan. **Exception:** Self injectable prescription medications (not including insulin) are covered as shown below.	
• **Self Injectable Prescription Medications** (other than insulin)	No benefits are available	80% of Allowed Charges subject to Plan Year deductible
	Medically Necessary self injectable prescription medication (excluding insulin) and related syringes when billed by a Pharmacy. All other exclusions and limitations shown under Prescription Drug apply.	
• **If This Plan is Secondary**	No benefits are available	
Preventive Care	Unless specified otherwise, the recommendations as mandated by the Affordable Care Act by the U.S. Preventive Services Task Force (USPSTF); evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration (HRSA); and the Advisory Committee on Immunization practices (ACIP) will apply. Frequency limits apply to In-Network and Out-of-Network services combined.	
• **Bone Density Testing**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Individuals qualifying for benefits shall at a minimum, include individuals: • previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or • on a prescribed drug regimen posing a significant risk of osteoporosis; or • with a lifestyle factors to such a degree as posing a significant risk of osteoporosis; or • with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.	

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Colorectal Cancer Screening**	100% of Allowed Charges	Not a Benefit
	Covered Persons Age 50 and older Routine frequency for persons at average risk when recommended by a Physician: • Sigmoidoscopy – once every five Plan Years; or • Barium enema (double contrast) - once every five Plan Years; or • Colonoscopy - once every ten Plan Years; or • Fecal occult blood testing as ordered Coverage is intended to be consistent with the guidelines for early detection screening and surveillance testing for colorectal cancer.	
• **Mammogram**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Limited to: • Upon a Physician's recommendation, Covered Persons at any age who are at risk for breast cancer or who have a first degree relative with a prior history of breast cancer; and • a single base line mammogram for Covered Persons age 35 but less than 40;and • a mammogram every Plan Year for Covered Persons age 40 and older.	
• **Nutritional Counseling** (for adults with risk factors and both adults and children with obesity)	100% of Allowed Charges	Not a Benefit
	Limited to four visits per Covered Person per Plan Year (no underlying chronic condition required). Services must be rendered by a Physician, certified nutritionist or certified or registered dietician.	
• **Prostate-Specific Antigen (PSA)** (exam and PSA)	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Limited to: • Any age with prior history of prostate cancer. • Age 50 and over for insured asymptomatic; and • Age 40 and over for Insured with a family history of prostate cancer or other prostate cancer risk factors.	
• **Routine Adult Physical (over age 18)**	100% of Allowed Charges	Not a Benefit
	Exam is limited to: Age 18 to age 39 (ends on 40th birthday) one physical every two Plan Years. Age 40 and older one physical every Plan Year. Related testing and immunizations (unless otherwise shown), follows the clinical standards and frequency recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices.	
• **Routine Child Care (up to age 19)**	100% of Allowed Charges	100% of Allowed Charges. Deductible does not apply
	Follows the clinical standards and frequency recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices.	

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Smoking Cessation Counseling**	100% of Allowed Charges	Not a Benefit
	Limited to two individual tobacco cessation counseling attempts per Plan Year will be covered. Each attempt may include a maximum of four intermediate or intensive sessions. The Plan Year benefit will cover up to eight sessions for Covered Persons who use tobacco.	
• **Well Woman** • Breastfeeding Support, Supplies, and Counseling	100% of Allowed Charges	Not a benefit
	In conjunction with each birth comprehensive breastfeeding support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for rental or purchase (if the purchase price is more cost efficient) of breastfeeding equipment (including related supplies) is covered.	
• BRCA Genetic Counseling/Testing (related to genetic screening for breast and ovarian cancer)	100% of Allowed Charges	Not a benefit
	Include related screening for BRCA1 or BRCA2 genes for women whose family history places them at increased risk for BRCA mutations.	
• Contraceptive Management	100% of Allowed Charges	Not a benefit
	Applies to all women with reproductive capacity.	
• Human Papillomavirus (HPV) DNA Testing	100% of Allowed Charges	Not a benefit
	For women with normal cytology results; screening begins at age 30 years and occurs no more frequently than every three Plan Years.	
• Prenatal Testing	100% of Allowed Charges	Not a benefit
	Will apply for all pregnant women including Dependent children.	
• Routine Screening Cervical Cytology/Pap Smear, and exam	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Limited to one per Plan Year to include annual pelvic exam, collection and preparation of a pap smear, and professional evaluation of the pap smear.	
• Well Woman Visit	100% of Allowed Charges	Not a Benefit
	Limited to one per Plan Year for adults to obtain the recommended preventive services that are age and developmentally appropriate.	
Prosthetics	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Prescription required. Rental only allowed to purchase price. Repair and maintenance allowed. No replacement or duplication allowed.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	Not a Benefit	Not a Benefit
Radiation Therapy ☎ • **Freestanding Facility**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible

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Service Type	In-Network Benefits	Out-of-Network Benefits
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Physician Office**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Refractive Surgery	Not a Benefit	Not a Benefit
Respiratory/Inhalation Therapy • **Freestanding Facility**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Physician Office**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
Skilled Nursing Facility (SNF)	Not a Benefit	Not a Benefit
Speech Therapy • **Freestanding Facility**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
• **Outpatient Hospital**	$15 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
• **Physician Office**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Therapy deductible
Substance Use Disorder Treatment • **Detoxification** ☎	Covered the same as Acute Care General Hospital for services and supplies related to Substance Use Disorder Detoxification.	
• **Inpatient Facility** ☎ • General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program • Partial Hospitalization	$200 Network Copayment per Admission then 100% of Allowed Charges, no other Copayment applies	80% of Allowed Charges after $200 inpatient deductible per Admission, no other deductible applies
• **Inpatient Physician**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Outpatient/Office**	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Medically Necessary family therapy visits are covered for members of the Family Unit.	
Surgical Charge Benefit • **Assistant Surgeon**	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• **Surgeon** • Inpatient	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
• Outpatient	$10 Network Copayment then 100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
	Excludes services covered under the Infertility provisions of the Plan.	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.317.2098. See the section entitled Cost Management Services for details.

Service Type	In-Network Benefits	Out-of-Network Benefits
Therapeutic Injections	100% of Allowed Charges	80% of Allowed Charges subject to Plan Year deductible
TMJ	Not a Benefit	Not a Benefit
Transplants ☎	**Per service type rendered.** Follows CMS guidelines.	
Urgent Care Facility	$10 Network Copayment then 100% of Allowed Charges One combined copay per date of service applies to all services billed by the facility/Physician.	80% or Allowed Charges subject to Plan Year deductible
	Includes all covered facility/Physician charges performed in the Urgent Care Facility	
Vision Therapy	Not a benefit	Not a Benefit
Voluntary or Elective Abortion	Same as Surgical Charge Benefit	80% of Allowed Charges subject to Plan Year deductible
Voluntary or Elective Sterilization (Female)	100% of Allowed Charges	Not a benefit
	Includes all related services such as anesthesia and facility charges.	
Voluntary or Elective Sterilization (Male)	Not a Benefit	Not a Benefit
Wigs	Not a Benefit	Not a Benefit

PRESCRIPTION DRUG BENEFIT

A Generic appeal process is available to GSEHP Enrollees.

Covered Drugs and Supplies	Limits and Copayments
Legend drugs (drugs obtainable only by prescription) for treatment of Illness or Injury. Diabetic Medications (including Insulin). Insulin Injections. Insulin Syringes. **Note**: list is not complete	**Student Health Center** $7 copay when filled at the **Student Health Center**. Balance at 100% of preferred allowance. $28 copay for Prescription Drugs to be used during the Summer period (120 day maximum) when filled at the Student Health Center. Balance at 100% of preferred allowance. **Network or mail order Pharmacy** **30 day supply:** Generic Drug -$5 copay preferred Brand Name Drug-$15 copay* Non-preferred Brand Name Drug- $40 copay* **90 day mail order:** Generic Drug -$5 copay preferred Brand Name Drug-$20 copay* Non-preferred Brand Name Drug- $65 copay* *When filled at an Express Scripts participating Pharmacy. (If a Brand Name Drug is purchased when a Generic is available, insured is responsible for the difference in cost between Generic and name Brand Name Drug, plus the copay). **Out-of-Network Pharmacy:** Prescription Drugs are reimbursed up to the amount the program would reimburse a Network Pharmacy for that prescription. If the prescription was filled with a preferred Brand Name Drug or non-preferred Brand Name Drug that has a Generic equivalent, the program will reimburse up to the amount it would reimburse a Network Pharmacy for filling the prescription with the Generic equivalent. Claims must be submitted to Express Scripts via paper claim for reimbursement.
Exclusions:	
Growth hormones, narcolepsy drugs, anabolic steroids, anorexients, anti-rejection drugs, fertility agents, flouride, impotency drugs, injectable (all injectable unless otherwise noted), IV injectable, multivitamins, immunization agents, cosmetic drugs, syringes other than for diabetes, and biological agents (blood and blood products). **Note**: list is not complete	
Your Doctor may be able to help you save money by prescribing Generic and preferred Brand Name Drugs if appropriate. You may obtain a list of preferred Brand Name Drugs at www.express-scripts.com , or call Express Scripts at 1.800.818.6632 if you have any questions.	
Exception: The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No copayment is required. Contact Express Scripts Customer Service department at 1.800.818.6632 for details.	

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

POMCO
1.866.317.2098

This Cost Management program does not apply if your primary coverage is Medicare or another group health benefit plan.

The patient or family member must call this number to receive certification of certain cost management services. This call must be made at least five working days in advance of services being rendered or within two working days after an emergency.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Pre-certification of the Medical Necessity for the following non-emergency services before

Medical and/or surgical services are provided:
Hospitalizations
Substance Use Disorder/Mental Disorder inpatient admissions
Home Health Care
Chemotherapy/Infusion (I.V.) therapyTransplants
Dialysis

(2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least five working days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Member
- The name, Member identification number and address of the covered Member
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician should contact the utilization review administrator **within two working days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50% of Allowed Charges after any applicable deductible or Copayment.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

MEDICAL PROCEDURE REVIEW - SECOND OPINION PROGRAM

Certain medical, diagnostic, or surgical procedures are performed either inappropriately or unnecessarily.

In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the voluntary second opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

Benefits will be provided for a second opinion consultation to determine the Medical Necessity of an elective surgical, medical, or diagnostic procedure.

Before a Covered Person has a surgery or procedure performed, the Covered Person may contact the utilization review administrator at:

POMCO
1.866.317.2098

(the number listed on the Member's ID card) to receive information on how to obtain a second opinion to

confirm the need for the surgery.

These additional consultations must be performed by Physicians who are:

(1) Board Certified Specialists in the area in which the operation is concerned; and

(2) not financially associated with either the surgeon originally recommending surgery or, in the case of a third opinion, with each other.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

COMPREHENSIVE MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible(s) shown in the Schedule of Benefits.

BENEFIT PAYMENT

Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of Essential Health Benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person in a Plan Year.

COVERED CHARGES

Covered Charges are the Allowed Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

THE STUDENT HEALTH CENTER

Most SUNY campuses have Student Health Centers which provide medical services, including appointments or walk-in service for routine primary care. Some also provide urgent care and limited specialty services. Students are urged to use the services of the campus Student Health Center when appropriate, and to verify the levels of care that can be obtained at the Student Health Center on the campus where the student is employed. On some campuses, the Student Health Center bills patients for services not covered under the campus mandatory health fee. Some of these services may be covered by the GSEHP. Contact your customer service department for details. Covered dependents of enrolled student Members do not have access to a campus Student Health Center. Covered spouses, Domestic Partners and dependent children enrolled in the Plan have the option to use a PPO Provider but are not required to use one. However, using a PPO Provider will result in a savings to the insured.

***Reference to the Student Health Center in this document will apply to Fellows only if they are registered students.**

MEDICAL SERVICES AND SUPPLIES

Allergy Care

Benefits are available for allergy treatment including, but not limited to, office visits, serum, scratch testing and laboratory testing. Allergy serum covered under the Prescription Drug Benefit will not be covered as a Medical Services and Supplies Benefit.

Ambulance Charges

The Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Charges for pre-Hospital medical emergency services are covered regardless of whether or not the Covered Person is actually transported to a Hospital.

Air or sea ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air or sea ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance.

Ambulatory Surgical Center

As defined, for Outpatient surgery. Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

Anesthesia

Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee other than an Advanced Physician Care Extender. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: Covered electroshock therapy.

Blood Services

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included. **Excludes** services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient).

Chemotherapy/Infusion (I.V.) Therapy

This benefit applies when a radiation or chemotherapy charge is incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A chemotherapy/infusion (I.V.) therapy charge is the Allowed Charge of a Physician for chemotherapy/ infusion (I.V.) therapy.

The type of drug for which benefits are provided is limited to drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs, subject to New York State mandates for coverage) or agents used to destroy microorganisms (such as antibiotic drugs). Ambulatory or home intravenous services ordered by a Physician to include intravenous medications, hydration and electrolyte replacement, and total parenteral nutrition.

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not covered under this chemotherapy benefit.

Chiropractic Care

Spinal Manipulation/Chiropractic services by a licensed doctor of chiropractic (D.C.) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening.

Consultations, Specialist

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

(1) **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.

(2) **Outpatient/Office Consultations.** Coverage for Outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.

(3) **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. Whether or not the second opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient’s decision whether to undergo the procedure. If the consulting specialist renders the procedure, consultation benefits are not payable.

(4) **Second Opinion Consultation for Cancer Diagnosis.** Benefits will be the same as any other Sickness for a second medical opinion by an appropriate Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Dental Care, Limited

Charges for Injury to the mouth, teeth, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(1) Emergency repair due to Injury to Sound Natural Teeth within twelve months of the Injury.

(2) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within twelve months of the Injury

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetic Supplies, Equipment, and Education

(1) The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

- **(a)** lancets and automatic lancing devices;
- **(b)** glucose test strips; ® blood glucose monitors;
- **(c)** blood glucose monitors for the visually impaired;
- **(d)** control solutions used in blood glucose monitors;
- **(e)** diabetes data management systems for management of blood glucose;
- **(f)** urine testing products for glucose and ketones;
- **(g)** oral anti-diabetic agents used to reduce blood sugar levels;
- **(h)** alcohol swabs;
- **(i)** injection aids including insulin drawing up devices for the visually impaired;
- **(j)** cartridges for the visually impaired;
- **(k)** disposable insulin cartridges and pen cartridges;
- **(l)** all insulin preparations;
- **(m)** insulin pumps and equipment for the use of the pump including batteries;
- **(n)** insulin infusion devices;
- **(o)** oral agents for treating hypoglycemia such as glucose tablets and gels; and ® Glucagons for injection to increase blood glucose concentration.

(2) Benefits will also be paid for Medically Necessary diabetes self-management education and education relating to diet. Such education may be provided by a Physician or the Physician's staff as a part of an office visit. Such education when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a Physician may be provided in a group setting.

When Medically Necessary, self-management education and diet education shall also include home visits.

Diagnostic Testing, X-ray, and Lab Charge Benefits

Diagnostic Testing, X-ray and Laboratory charges are the Allowed Charges for X-rays and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

(1) Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.

(2) Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician.

(3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician.

Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital or other covered facility.

Charges for the following will not be included in this section:

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

(4) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Dialysis

Benefits are available for Service or Supplies related to Outpatient kidney dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Durable Medical Equipment

Rental of Durable Medical or Surgical Equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery and service are not covered.

Food Supplements

Limited Coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a Physician, or other licensed healthcare provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders. $2,500 Benefit maximum per Plan Year. Plan Coverage is limited to the following:

(1) **Aminoacidopathies Formula.** Certain nutritional supplements (formulas) are covered when found Medically Necessary for the therapeutic treatment of the following aminoacidopathies (disorders that prevent the body from properly digesting amino acids): phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

(2) **Enteral Formulas.** The prescribing healthcare Provider must state in writing that the enteral formula is clearly Medically Necessary and has been proven effective as the disease-specific

regimen for those individuals who are or will become malnourished or who suffer from disorders, which left untreated, cause chronic disability, mental retardation or death. These specific diseases include, but are not limited to, aminoacidopathies, gastric motility disorders such as chronic intestinal pseudo-obstruction and multiple severe food allergies that if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death.

(3) **Modified Solid Food Products**. Coverage is available for modified solid food products that are low protein, or which contain modified proteins that are Medically Necessary for certain inherited diseases of amino acid and organic acid metabolism.

Foot Care and Podiatry Services

Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Services or supplies for foot orthotics, orthopedic shoes or shoe inserts are not covered (please refer to **Plan Exclusions**).

Home Health Care Services and Supplies

Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

The home health care must start within three days following a Hospital Confinement, for the same or related condition for which inpatient care was necessary.

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

Hospice Care Services and Supplies

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

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed;

(2) Day care service provided by the Hospice Agency;

(3) Home care and Outpatient Services provided by the hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a Home Health Aide;

(4) Physical, occupational, speech, and respiratory therapy;

(5) Medical social services and nutritional services;

(6) Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;

(7) Medical supplies and drugs and medications considered approved for the patient's condition.

(8) Benefits are not payable if the drugs or medications are of an Experimental nature;

(9) Durable Medical Equipment;

(10) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency; and

(11) Bereavement counseling for the family, limited to five visits per family preceding or following the Covered Person's death.

During this period of acceptance, all the patient's medical services must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency.

Hospital Charges

This benefit applies when a Hospital charge is Incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

(1) **Inpatient Hospital Care.** The Usual, Reasonable, and Customary Charges for room and board are payable as described in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

The Plan pays the actual semi-private rate for room and board charges by a Hospital or other covered inpatient health facility. If the inpatient facility does not have a semi-private rate, the rate shall be 90% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

Coverage for private room charges will be limited to the Average Semi-private Room Rates, whatever the reason for private room use.

The Allowed Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

(2) **Outpatient Emergency Accident Care and Emergency Medical Care.**

(a) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within 72 hours of the accident.

(b) Care for the initial treatment of a Medical Emergency, as defined in this Plan, within 72 hours of the onset of the Medical Emergency.

Emergency Room expenses incurred will be paid only for Sickness or Injury which fulfills the definition of "Medical Emergency". These expenses will not be paid for minor Injuries or minor Sicknesses.

(3) Outpatient Surgical Care.

(4) Clinic Services or Supplies.

(5) Other Services and Supplies such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual, Reasonable and Customary charge.

In-Hospital/Facility Physician's Care Benefits

This benefit applies when a medical charge is incurred for the care of a Covered Person's Injury or Sickness during a covered Hospital/facility confinement.

However, a medical charge will not include:

(1) a charge for care not rendered in the presence of a Physician; or

(2) a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

Intercollegiate Sports

Paid as any other Injury up to a Plan Year maximum of $500 per Injury (course of treatment).

Maternity

The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your spouse. Charges related to Pregnancy of dependent child are covered, however the child born of the dependent child's Pregnancy is not covered. Coverage is provided for expenses connected with elective abortion. The Plan excludes services or supplies related to surrogate maternity care. The payment for childbirth, cesarean section or other termination of a Pregnancy will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. For additional covered maternity services please refer to the Preventive Care Section of this document.

Medical Supplies (Home Use)

Are not a benefit unless they fit the criteria below. Benefits are available for certain medical and surgical supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

(1) Part of an approved Home Health Care, Hospice, Chemotherapy or surgery Service.

(2) Diabetic Supplies/Equipment is covered under a separate benefit.

Please refer to the Schedule of Benefits and the benefit details listed in this section, Comprehensive Medical Benefits for details.

Mental Disorder Care

Regardless of any limitations on benefits for Mental Disorder treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

(1) **Inpatient**. Coverage for inpatient Mental Disorders in an acute care Hospital or Psychiatric Facility (including Partial Hospitalization) is available only when medical documentation shows that the patient required the inpatient stay, and when the course of treatment could only be given on an inpatient basis in an acute setting.

The Plan allows coverage for Inpatient Mental Disorder Care in a Residential Treatment Center, Group Home or Halfway House up to the limits shown in the Schedule of Benefits. Care must be Medically Necessary, rendered in an “approved facility”, and the admission must be approved by the utilization review administrator (see the section entitled “Cost Management Services” for details).

The phrase “approved facility” shall mean a facility approved for care by the Claims Administrator. If the Residential Treatment Center, Group Home or Halfway House is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Laws of New York State. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care organizations for the provision of mental health, alcoholism or drug abuse treatment.

Counseling or therapy primarily rendered for marital, family and sexual problems, educational services (including dysfunctional or vocational training), or Custodial Care is not covered. Recreation and personal items are not covered.

(2) **Outpatient**. Covered Charges for care, supplies and treatment of outpatient Mental Disorder care are payable as shown in the “Schedule of Benefits” for Services rendered and billed by al New York State licensed mental health professionals performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license; and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, physician’s corporation or clinic for the services of a similarly licensed Provider will be covered.

Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups.

Under no circumstances will benefits be provided for therapy that includes the satisfaction of requirements for professional training.

Newborn Care

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible dependent and is neither injured nor ill.

The benefit is limited to Usual, Reasonable, and Customary Charges for nursery care while the newborn child is Hospital Confined as a result of the child's birth.

The benefit is limited to the Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined. Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Nursing Care, Private Duty

The private duty nursing care by a licensed registered nurse (R.N.). Covered Charges for this service will be included to this extent:

(1) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and care must be so intense that the Hospital staff could not be expected to render such care. Shortage of general nursing staff does not establish medical necessity for private duty nurses

(2) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for Outpatient nursing care are those shown under Home Health Care Services and Supplies or billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional registered nurse services.

Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or household member.

Occupational Therapy

Services rendered by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Orthotics

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot orthotics are not covered.

Oxygen

Oxygen and supplies for its administration when found Medically Necessary and appropriate for self-care home use.

Physical Therapy

Services rendered by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.

Physician Care

The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, Outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, Mental Disorder care, Substance Use Disorder care, podiatrist care or foot care, rehabilitation therapies, are covered separately.

Preadmission Testing

The Medical Benefits percentage payable will be for diagnostic lab tests and X-ray exams when:

(1) performed on an Outpatient basis within seven business days before a Hospital Confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital Confined.

Covered Charges for this testing will be payable services even if tests show the condition requires medical treatment prior to Hospital Confinement or the Hospital Confinement is not required.

Benefit limited to routine tests such as CBC, Urinalysis, EKG and chest X-ray. Major diagnostics procedures such as cat-scans and blood chemistries will be paid under the appropriate Outpatient benefit.

Preventive Care

Among the provisions of the Affordable Care Act is expanded coverage for preventive care services. These new standards will apply unless otherwise specified in the **Schedules of Benefits**. POMCO's medical criteria may apply to frequency limitations.

The following is a listing of the most common services. This listing is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration (HRSA); and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). Ancillary charges associated with any preventive care service will be available at no cost share.

See http://www.healthcare.gov/center/regulations/prevention/recommendations.html. If these standards change, the Plan will automatically cover the new recommended standards.

The Plan will comply within one year of the effective date of all new recommendations or guideline changes; the Plan will not cover any item or service that is no longer a recommended preventive service.

Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness.

(1) **Bone Density Screening.** Bone mineral density measurement or test to detect osteoporosis is covered for Covered Persons:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- With such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(2) **Colorectal Cancer Screening** for Covered Persons Age 50 and older. Routine frequency for persons at average risk when recommended by a Physician:

- Sigmoidoscopy – once every five years; or
- Barium enema (double contrast) - once every five years; or
- Colonoscopy - once every ten years; or
- Fecal occult blood testing as ordered.

Coverage is intended to be consistent with the guidelines for early detection screening and surveillance testing for colorectal cancer.

(3) **Mammography**

- At any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
- A single baseline mammogram for Covered Persons aged 35-39; and age 40 or over for Covered Persons; limited to once a year

(4) **Nutritional Counseling.** The Plan will cover wellness nutritional counseling (no underlying chronic condition required) up to the benefit maximums shown in the Schedules of Benefits. Services must be rendered by a Physician, certified nutritionist or certified and registered dietician. Diabetic education is covered separately under the section entitled Medical/ Surgical Services and Supplies.

(5) **Pap Smear/Screening Cervical Cytology** to include:

- Pap smear (age 18 and older); and
- HPV-DNA test (according to FDA-approved guidelines for routine screening).

(6) **Prostate Exam and Test.** Benefits are available for routine screening of the prostate gland, including PSA (prostate-specific antigen) testing.

- Coverage is limited to once per Calendar Year for men from age 50.
- Coverage is available for men at any age who have a prior medical history of prostate cancer and for men age 40 and older if determined to be at high risk for prostate cancer. Such high risk factors include a family history of prostate cancer and/or African-American ancestry

(7) **Routine Adult Physical Exams**, to include screening tests and age-appropriate immunizations.

(8) **Routine Well Child Care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits, related testing and immunizations.

Coverage is intended to be consistent with the clinical standards supported by the Heath Resources and Services Administration (HRSA); and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). If these standards change, the Plan will automatically cover the new recommended standards.

(9) **Smoking Cessation Counseling (In-Network only benefit).** Two individual tobacco cessation counseling attempts per Calendar Year will be covered. Each attempt may include a maximum of four intermediate or intensive sessions. The annual benefit will cover up to eight sessions for Covered Persons who use tobacco.

(10) **Well Woman**

- **Breastfeeding support, supplies, and counseling.** In conjunction with each birth the Plan includes coverage for comprehensive lactation support and counseling, by a trained Provider during Pregnancy and/or in the postpartum period; and

  The rental or purchase (if the purchase price is more cost efficient) of breastfeeding equipment. Coverage for related disposable supplies used with the breast feeding equipment is also covered.

- **BRCA Genetic Counseling/Testing.** Includes related screening for BRCA 1 or BRCA 2 genes for women whose family history places them at increased risk for BRCA mutations.

- **Contraceptive management.** The Plan will cover FDA approved contraceptive methods including injectable drugs, implantable drugs, barrier contraceptives, patches, emergency contraceptives, and contraceptive devices prescribed by a professional Provider.

  FDA approved injectable contraceptives, implantable contraceptives and contraceptive devices are covered **only** under the “Medical Benefit” section of the Plan. Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.

  FDA approved Oral contraceptives, barrier contraceptives, contraceptive patches, emergency contraceptives (retail only) are covered **only** under the “Prescription Drug Benefits” section of the Plan.

  Elective (female only) sterilization is covered under this benefit.

  Benefits are not provided for abortifacient drugs or any drug or device obtained without a prescription. Male contraceptive medicines or devices or male elective sterilization are not covered, regardless of intended use. **Exception:** Over the counter emergency contraceptives will be covered at the retail Pharmacy level as shown in the “Prescription Drug Benefits” section of this document.

- **Human papillomavirus (HPV) DNA testing.** High risk human papillomavirus DNA testing in women with normal cytology results.

- **Prenatal testing**. Screening for gestational diabetes (between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

- **Well-woman visit** for adults to obtain all recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Additional visits may be necessary to obtain all USPSTF recommended preventive services, depending on the woman's health status and needs, and risk factors. These services include but are not limited to mammograms and cervical cancer screenings as shown below.

  The visit should include annual screening and counseling for interpersonal and domestic violence. Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women. Annual counseling for sexually transmitted infections for all sexually active women.

Prosthetics

The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Radiation Therapy

This benefit applies when a radiation or chemotherapy charge is incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A radiation charge is the Allowed Charge of a Physician for X-ray, radium or radiotherapy treatment.

Radiation charges will not include charges for diagnostic or cosmetic procedures.

Respiratory/Inhalation Therapy

Services rendered for short-term Outpatient inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not covered.

Speech Therapy

Services rendered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

Substance Use Disorder Care

Regardless of any limitations on benefits for Substance use Disorder treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

(1) **Inpatient.** Coverage for inpatient Substance Use Disorder Care in an acute care Hospital or Substance Use Disorder Facility (including Partial Hospitalization) is available only when medical documentation shows that the patient required the inpatient stay, and when the course of treatment could only be given on an inpatient basis in an acute setting.

Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits. Expenses for inpatient Substance Use Disorder (alcohol or drug abuse) rehabilitation are covered separately from detoxification.

The Plan allows coverage for Inpatient Substance Use Disorder Care in a Residential Treatment Center, Group Home or Halfway House up to the limits shown in the Schedule of Benefits. Care must be Medically Necessary, rendered in an "approved facility", and the admission must be approved by the utilization review administrator (see the section entitled "Cost Management Services" for details).

The phrase "approved facility" shall mean a facility approved for care by the Claims Administrator. If the Residential Treatment Center, Group Home or Halfway House is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Laws of New York State. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care organizations for the provision of mental health, alcoholism or drug abuse treatment.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

(2) **Outpatient.** Covered Charges for Outpatient Care of Substance Use Disorders will be subject for services by a certified alcohol or Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an approved plan of Outpatient Care.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Surgical Charge Benefits

This benefit applies when a surgical charge is incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

(1) **Assistant Surgeon.** Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The Maximum Payment for all assistant surgeons for each surgical procedure is 20% of the value listed for the surgery.

(2) **Surgeon.** Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

(a) If two or more procedures are performed through the same incision or in immediate succession at the same operative session by one (1) surgeon, benefits will be determined based on the Allowed Charge for the primary procedure; 50% of the allowance for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

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

(3) Reconstructive Surgery. The Plan Covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

Reconstructive mammoplasties will also be considered Covered Charges. The federally mandated mammoplasty coverage will include reimbursement for:

(a) reconstruction of the breast on which a mastectomy has been performed,

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Transplants - Organ/Autologous Bone Marrow/Stem Cell

Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included for Medicare coverage by the Centers for Medicare & Medicaid Services (CMS). Transplants must meet the Medicare criteria for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

(1) Recipient Expenses. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant surgery and recovery; and post discharge care.

(2) Donor Expenses.

(a) Coverage includes expenses Incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) to the extent such charges are not reimbursed by the donor's plan.

(b) If you or your Dependent act as a donor, the donor expenses **will not** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. No benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member.

(3) Autologous Bone Marrow/Stem Cell. Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only

then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

Urgent Care Facility

As defined. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Member is a Member who is a SUNY graduate student on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer or is a post-doctoral scholar who is receiving non-wage payments from the Research Foundation for SUNY in support of academic study or fellow-initiated research and meets the Research Foundation's eligibility requirements.

Advanced Physician Care Extender or Physician Extender includes physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Allowed Charge - The Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for covered medical services rendered and billed by a covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing Outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Care, a national accreditation organization recognized by the Claims Administrator or approved by Medicare to render Outpatient surgery services. If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Center.

Biomechanical Prosthetic Device is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

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

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

Brand Name Drug means a trade name medication.

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

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

Coinsurance means a fixed percentage (usually 20% Out-of-Network) of the Allowed Charges that a Covered Person must pay for certain services requiring Coinsurance.

Copayment means a pre-determined fee or charge a Covered Person pays a Provider at the time of service. Copayments vary according to the type of service and are outlined in the Schedule of Benefits.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Member, or dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dependent is an Enrollee's spouse, Enrollee's Domestic Partner or an Enrollee's child who meets the conditions shown in the subsection entitled "Eligibility" in this booklet.

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

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable supplies may be allowed if required to operate the medical equipment.

Emergency Medical Condition (prudent person) - a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy to the health of an individual (including the health of a pregnant woman or her unborn child) or others, if severe behavioral condition; impairment to bodily function; dysfunction of any organ; or serious disfigurement.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services to evaluate an Emergency Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is The Research Foundation for the State University of New York.

Enrollee is an eligible Member or COBRA participant under whose Member Identification number enrollment is made.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits means benefits as defined by the Secretary of the Department of Health and Human Services (HHS) as required by the Affordable Care Act (ACA). Benefits include the following essential benefit class categories:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Claims Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Claims Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Claims Administrator will be guided by the following principles:

(1) if the drug or device 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; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 a standard means of treatment or diagnosis.

Reliable Evidence shall mean 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, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Notwithstanding the foregoing, if the disease or condition being treated is certified by the attending Physician to be "rare" within the meaning of the Rare Diseases Act of 2002, i.e., "any disease or condition that affects less than 200,000 persons in the United States" such that there is no Reliable Evidence regarding appropriate treatment, and the drug, device, medical treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function and determined to be the most appropriate drug, device, medical treatment or procedure in the particular case, then such drug, device, medical treatment or procedure shall not be denied on the basis of Experimental and/or Investigational.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

If any of the entities used to determine the Investigational status of a drug, a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will not make payment for related retroactive incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

Family Unit is the covered Member and the family members who are covered as dependents under the Plan.

Fellow means a post-doctoral scholar who is receiving non-wage payments from the Research Foundation for SUNY in support of academic study or fellow-oriented research.

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

Foster Child means a child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Member has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Member's; and the child meets the definition of "foster child" under Internal Revenue Code 152 (f) (1).

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

Generic Drug means a Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

Group Home is an institution specifically designed for the active treatment of a Mental Disorder or Substance Use Disorder. If it is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Laws of

New York State as a Group Home. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations as a Group Home for the provision of mental health, alcoholism or drug abuse treatment.

Halfway House is an institution specifically designed for the active treatment of a Mental Disorder or Substance Use Disorder. If it is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Laws of New York State as a halfway House. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations as a Halfway House for the provision of mental health, alcoholism or drug abuse treatment.

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

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

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

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

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

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

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

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

Hospital Confined/Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

Hospitalist is a Physician that assumes the care of hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred means those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

Infertility means incapable of producing offspring.

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

In-Network or **Network** is an organization, Physician, Hospital, Pharmacy or other Provider that, at the time Covered Services or Supplies are provided, is part of the participating Network(s) selected by the Plan. The Network Provider has a contract or agreement with the Network organization and the Plan to bill negotiated charges or allowances for Covered Services or Supplies when Incurred by Covered Persons.

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

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

Maintenance Care - Care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient’s disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments.

Medical Emergency a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy (or others, if severe behavioral condition), impairment to bodily function, dysfunction of any organ, or serious disfigurement.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claim Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

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

Member is a covered Employee or Fellow who meets the eligibility requirements for coverage according to criteria established by the Plan as set forth in the section entitled “Eligibility, Funding, Enrollment, Effective Date and Termination” shown previously in this document.

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Orthotics - An external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

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

Out-of-Network is an organization, Physician, Hospital, Pharmacy or other Provider that, at the time Covered Services or Supplies are provided, does not have a contract or agreement with the participating Provider Network selected by the Plan to provide medical Services or Supplies to the Covered Persons under the Plan for scheduled or negotiated charges or allowances.

Partial Hospitalization program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts at least 20 hours per week no charge is made for room and board. Partial Hospitalization also encompasses Partial Hospitalization programs that provide overnight boarding.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Licensed Clinical Social Worker or Psychiatric Registered Nurse (for care of Mental Disorders), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means The Research Foundation for the State University of New York Graduate Student Employee Health Plan, which is a benefits Plan for certain Active Employees and Fellows of The Research Foundation for the State University of New York and is described in this document.

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

Plan Sponsor means The Research Foundation for the State University of New York.

Plan Year means the 12-month period beginning on August 15th and ending on August 14th of the following Calendar Year.

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetics - The making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider - Any legally licensed Physician or any physical therapist, speech therapist, Licensed Clinical Social Worker or Psychiatric Registered Nurse (for Mental Disorder care), or other health care Providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for covered services given by covered Physicians or other healthcare Providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility means a private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator as an inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorder.

Residential Treatment Center is an institution specifically designed for the active treatment of a Mental Disorder or Substance Use Disorder. If it is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Laws of New York State as a Residential Treatment Center. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations as a Residential Treatment Center for the provision of mental health, alcoholism or drug abuse treatment.

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

Sound Natural Teeth means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

Student Health Center is located on most SUNY campuses and provides medical care for students registered on the campus. The Student Health Center is a Network Provider for this Plan.

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

Substance Use Disorder Facility - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the treatment of Substance Use Disorder (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment of Substance Use Disorder.

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

Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by Physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a Physician's office.

Usual, Reasonable, and Customary Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual, Reasonable, and Customary Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual, Reasonable, and Customary.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

(1) **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.

(2) **Birth Control.** Benefits are not provided for abortifacient drugs or any contraceptive drug or device obtainable without a prescription. Male contraceptive medicines or devices or male elective sterilization are not covered, regardless of intended use. **Exception:** This Plan will follow the federal Affordable Care Act Women's Preventive Services provisions for women's contraceptive management as shown in the section entitled "Preventive Care". Oral contraceptives contraceptive patches, and over the counter emergency contraceptives (retail Pharmacy only) are covered **only** under the "Prescription Drug Benefits" section of the Plan.

(3) **Cosmetic.** Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

(4) **Counseling/Analysis/Support Groups**. Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups.

(5) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(6) **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances for treatment of temporomandibular joint disorders (TMJ) or similar disorders. Exception: Charges by a dentist or Physician for care otherwise considered medical such as reduction of fractures of facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues. Limited dental care given for accidental Injury to Sound Natural Teeth within 12 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

(7) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.

(8) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical developmental for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, birth defects, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest Mental Disorder or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

(9) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual, Reasonable, and Customary Charge.

(10) **Exercise Programs.** Exercise programs for treatment of any condition, including cardiac rehabilitation. Exception for Physician-supervised, occupational or physical therapy covered by this Plan.

(11) **Experimental or Not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

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

(13) **Flight** in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft.

(14) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes, foot orthotics or other supportive foot devices are excluded.

(15) **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(16) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(17) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(18) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. Exceptions: Services covered under the well child sections of this Plan and F.D.A. approved Medically Necessary cochlear implant is covered under the Plan's prosthetic benefit.

(19) **Hospital/Facility employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or any inpatient facility where care is received and paid by the Hospital or facility for the service. **Exception:** Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.

(20) **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes

of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(21) **Illegal Care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to Federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

(22) **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(23) **Implants.** Claims for implants billed by a facility may be denied unless they are submitted with the invoice.

(24) **Impotence.** Care, treatment, services, or medications in connection for treatment of impotence.

(25) **Infertility**. Care, supplies, services and treatment for Infertility, artificial insemination, or in vitro fertilization.

(26) **Injury** sustained while a) participating in any Interscholastic (intercollegiate) sport, contest or competition; b) traveling to or from such sport, contest or competition as a participant; or c) while participating in any practice or conditioning program for such sport, contest or competition, in excess of the $500 benefit maximum per Injury as specifically provided in benefits for intercollegiate sports.

(27) **Mental Disorder Care** except as specifically provided in benefits for Mental Disorders.

(28) **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

(29) **Missed Appointments/Phone Consultations/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services. Services or supplies not actually received by the patient or incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.

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

(31) **No-Fault Auto Insurance/Automobile Insurance** for which the Covered Person is eligible to receive benefits through mandatory No-Fault Auto Insurance or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault

Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. charges for services or supplies not paid by the No-Fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent Allowable Fees would have otherwise been payable by this Plan. **Note:** No-fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

(32) **Non-Emergency Hospital Admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

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

(34) **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(35) **Not Specified as Covered.** Non-traditional medical services, treatments and supplies (e.g., alternative medicine including massage, biofeedback and acupuncture) which are not specified as covered under this Plan.

(36) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. **Exception:** Limited services for nutritional counseling is allowed under the Preventive care section of the Plan.

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

(38) **Orthotics (foot).** Charges in connection with foot orthotics.

(39) **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.

(40) **Plan Design Excludes.** Charges excluded by the Plan design as specified in this document.

(41) **PUVA Therapy.** Psoralen with ultraviolet A radiation.

(42) **Rehabilitation Facility.** Treatment, services or supply provided in or by a rehabilitation facility.

(43) **Relative or Self Giving Professional Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(44) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care (including immunizations), or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(45) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan. Exception the extension of benefits as specifically covered in the Schedule of Benefits.

(46) **Sex Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(47) **Skilled Nursing Facility.** Treatment, services or supply provided in or by a skilled nursing facility.

(48) **Student Health Center.** Services provided normally without charge by the Student Health Center of the Member; or services covered or provided by the student health free.

(49) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions). Exception: Conditional payments shown in **Right of Subrogation**.

(50) **Substance Use Disorder.** Except as specifically provided in benefits for Substance Use Disorder.

(51) **Surgical Sterilization.** Care and treatment for male surgical sterilizations or reversal of male or female sterilizations. **Exception:** Female sterilizations are covered as shown under the Preventive Care section of the Plan..

(52) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for Newborns who meet the child eligibility requirements and who are enrolled under the individual + 1 or family coverage.

(53) **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services specifically listed in this Plan.

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

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the administrator of the Pharmacy drug Plan.

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No copay is required. Contact Express Scripts Customer Service Department toll-free at 1.800.818.6632 for details.

COPAYMENTS

The Copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The Copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription is limited to a 30-day supply at a retail Pharmacy, and up to a 90-day supply at a mail order Pharmacy. **Exceptions:** For Prescription Drugs to be used during the summer period and filled at the Student Health Center the limit is a 120-day supply. Some Prescription Drugs have a quantity/dosage limit other than the 30-day and 90-day limit shown above.

Copayment is waived for Generic Drug Prescription Drugs that are mandated as covered under the "Preventive Care" provisions of the federal Patient Protection and Affordable Care Act. If a Generic Drug version is not available or would not be medically appropriate for the patent as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts. Contact the Express Scripts Customer Service Department toll-free at 1.800.818.6632 for details on quantity limits and "Preventive Care" provisions under the Plan.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, Prescription Drugs are reimbursed up to the amount the program would reimburse a Network Pharmacy for that prescription. If the prescription was filled with a preferred Brand Name Drug or non-preferred Brand Name Drug that has a Generic equivalent, the program will reimburse up to the amount it would reimburse a Network Pharmacy for filling the prescription with the Generic equivalent. Claims must be submitted to Express Scripts via paper claim for reimbursement.

Your Plan may prefer some medications over others. These are called "Formulary drugs", and their Copayment is lower. Your Copayment is lowest for Generic Drugs. Your Copayment is higher for (Formulary) preferred Brand Name Drugs. Your Copayment is highest for (non-Formulary) non-preferred Brand Name Drugs.

Your Doctor may be able to help you save money by prescribing Generic and preferred Brand Name Drugs if appropriate. You may obtain a list of preferred Brand Name Drugs at www.express-scripts.com , or call 1.800.818.6632.

PREAUTHORIZATION REQUIREMENTS

Some drugs require pre-authorization before drug benefits become available. The Network or mail order Pharmacy will not provide Coverage unless the drugs have been approved for benefit payment. If a Pharmacy advises you that you need pre-authorization, a letter of Medical Necessity from your attending Physician should be sent to the Express Scripts. You or your Physician may also call Express Scripts to confirm whether or not a drug requires pre-authorization. Contact Express Scripts Customer Service Department toll-free at 1.800.818.6632.

The following are examples of drugs that must be preauthorized:

Gleevec
Iressa
Cox II (all forms)
Oral Ribavirin
Leflunomide

COVERED PRESCRIPTION DRUGS

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

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

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered under Prescription Drug benefits. Other Medically Necessary self injectables and syringes are covered under the section entitled Medical Benefits shown previously in this document.

(4) Prescription smoking cessation and preventive medications are covered as required under the federal Patient Protection and Affordable Care Act. If these standards change, the Plan will automatically cover the new recommended standards.

The Plan will comply within one year of the effective date of all new recommendations or guideline changes; the Plan will not cover any item or service that is no longer a recommended preventive service. No copayment is required for the following:

- Aspirin when prescribed by a Physician, limited to males ages 45 years through 79 years to reduce risk of myocardial infarction and to females ages 45 years through 79 years to reduce risk of ischemic stroke.

- Vitamin supplements when prescribed by a Physician for over the counter and prescription forms of folic acid for females to age 50 years who are planning or capable of Pregnancy; iron (ferrous sulphate) supplements to age one year for children who are at increased risk of iron deficiency anemia; and fluoride for children to age five years.

- Smoking/tobacco use cessation agents when prescribed by a Physician for Covered Persons over age 18 for over the counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents. Limited to a 90 day supply per Covered Person per Plan Year. Exception: Chantix is limited to a 180 day supply per Covered Person per Plan Year.

- FDA approved contraceptives when prescribed by a Physician for females with reproductive capacity to include Generic Drug oral contraceptives, patches, and emergency contraceptives. Covered Brand Name contraceptives are subject to the Brand Name Copayments shown in the Schedule of Benefits if a Generic Drug version of the drug is available. **Exception:** If a Generic Drug version would not be medically appropriate for the patent as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts. Over the counter emergency contraceptives are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs.

- Vitamin D2 or D3 containing 1,000IU or less per dosage form or combination vitamin D products that also contain calcium (combination of two agents only for the combination) when prescribed by a Physician, limited to Covered Persons age 65 years or older.

LIMITS TO THIS BENEFIT

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

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

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

(3) Quantity limits that could apply to controlled substances based on state regulations.

EXPENSES NOT COVERED

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite Suppressants/Dietary/Vitamin Supplements.** Medicines or drugs whether or not prescribed by a Physician's prescription, for appetite suppressants, dietary supplements or vitamin supplements, including nutritional supplements or food products. See the exceptions for aspirin, folic acid, vitamin D, and iron (ferrous sulphate) specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.

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

(4) **Devices.** Devices of any type, even though such devices may require a prescription, including contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

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

(7) **Immunization.** Immunization agents or biological sera.

(8) **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(9) **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital Confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

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

(11) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

(12) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(13) **No Prescription.** A drug or medicine that can legally be bought without a written prescription is not covered. This does not apply to injectable insulin or drugs (aspirin, folic acid, iron, vitamin D and female barrier and emergency contraceptives) as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.

(14) **Other Exclusions** as listed in the Schedule of Benefits.

(15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

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

Network Provider benefits are always paid directly to the Network Provider. Benefits for a Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization. You may not assign your right to take legal action under this Plan to any Provider of service.

When the claim is processed, POMCO will send you an Explanation of Benefits Statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accuratrely.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office or the Plan Administrator.

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

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

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

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

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

POMCO
PO Box 6329
Syracuse, New York 13217
1.866.317.2098

WHEN CLAIMS SHOULD BE FILED

Medical Claims. Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless

(1) it is not reasonably possible to submit the claim in that time; and

(2) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

Prescription Claims. When you use one of the Express Scripts participating pharmacies to obtain a 30-day supply of drugs for a covered Injury or Illness, you will be required to pay a Copayment. Please present your I.D. card to the Pharmacy when the prescription is filled. If you do not present your I.D. card or you do not use a participating Pharmacy, you will be responsible for paying the full cost of the prescription. If this happens you must submit the paper claim to Express Scripts for reimbursement at the address below. Include your Member identification number on the claim form and attach the prescription receipt(s).

Express Scripts
P.O. Box 14711
Lexington, KY 40512
Phone #: 1.800.818.6632
Internet Access: www.express-scripts.com

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. A claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan

Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits

for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days

Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal
Review of adverse benefit determination	60 days

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination or Final Adverse Determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The date of service, the health care Provider, and the claim amount, if applicable.

(2) The specific reason or reasons for the adverse determination.

(3) Reference to the specific Plan provisions on which the determination was based and the Plan's standard, if any, that was used in denying the claim.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal appeals and external review procedures, including information about how to initiate an appeal, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) The claimant will also be provided free of charge with any new or additional rationale or evidence considered, relied upon, or generated by the Plan, or at the direction of the Plan, in connection with the Claim with sufficient notice, assuming the Plan has received the information in a timely manner, so that the claimant has a reasonable opportunity to respond.

(8) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(9) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided upon request.

INTERNAL APPEALS

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended. When a claimant receives an Adverse Benefit Determination, the claimant or an authorized representative acting on behalf of the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. Submit all appeals to the:

POMCO, Appeals Department
P.O. Box 6329
Syracuse, NY 13217

The period of time within which an Adverse Benefit Determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or

appropriate, the Plan or Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

EXTERNAL APPEALS

(1) Your Right to an External Appeal

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended and applicable New York State Insurance Law, as amended (regardless of state of residence).

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the state to conduct such appeals.

(2) Your Right to appeal a Determination that a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements, you may appeal to an external appeal agent if you satisfy the following two criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and
- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

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

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following two criteria:

- The service must otherwise be a Covered Service under the Plan; and
- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

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

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

  For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

(4) The External Appeal Process

If, through the Plan's internal appeal process, you have received a Final Adverse Determination upholding a denial of coverage on the basis that the service is not Medically Necessary, is an Experimental or Investigational treatment, or you have received a Final Adverse Determination of rescission of coverage, you have four months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the Final Adverse Determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You must then submit the completed application to the Claims Administrator at the address indicated on the application. If you satisfy the criteria for an external appeal, the Claims Administrator will forward the request to a certified external appeal agent.

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

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from

you, your Physician, or the Plan. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health, or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment the Plan will provide coverage subject to the other terms and conditions of the Plan. Please note that if the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

(5) Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the Claims Administrator. You may appoint a representative to assist you with your external appeal request; however, the Claims Administrator may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law (regardless of state of residence), your completed request for appeal must be filed with the Plan within four months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover Experimental or Investigational treatments. However, the Plan shall cover an Experimental or Investigational treatment approved by an external appeal agent in accordance with the External Appeal Section of the Plan. If the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received. Exception: See Medicare Integration described below.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. Medicare integration is shown below.

Benefit Plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise, student health or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare and Tricare.

(5) Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual, Reasonable, and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations. When medical payments are available under vehicle insurance, this Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Plan will automatically follow the amended regulations.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

(c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would

have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare or a state child health plan to the extent required by federal law.

Claims Determination Period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

MEDICARE

You or your dependents are responsible for Medicare enrollment. If you or your dependent are not contacted by the Social Security Office at least three months before a 65th birthday or within 12 months after starting Social Security disability benefits, you or your dependent should call your local Social Security office for assistance. *Persons of any age who are diagnosed with end state kidney disease or with Lou Gehrig's disease (amyotrophic lateral sclerosis or ALS) should contact the Social Security Office for eligibility and enrollment details when first diagnosed.* If this Plan is primary coverage for your health care, Medicare regulations allow you (but not your Domestic Partner or same–sex spouse) to delay Medicare enrollment until this Plan becomes secondary according to Medicare Secondary Payer rules. Your local Social Security Office can provide details on enrollment requirements and penalties for late enrollment.

This Medicare integration provision applies to all persons eligible for primary Medicare coverage even if the person is not actually enrolled in Medicare.

(1) **Medicare Payment Integration**. The Plan determines the allowable fee first, then pays the difference between the allowable fee and Medicare's payment up to the lesser of the balance of the bill or the Plan's normal benefit.

(2) **Not enrolled in Medicare**. This integration will apply to persons eligible for Medicare whether

or not actually enrolled in Medicare or incurs services in a Veterans Administration Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For Services incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

(3) **Medicare Private Contract Options**. This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain providers, Medicare will not pay. The patient is responsible for the entire charge. The provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Reasonable, and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

(4) **Medicare Part C (Medicare Advantage).** This integration will not apply when Medicare and a Medicare-sponsored Advantage Plans deny coverage due to its enrolled beneficiaries failure to abide by the HMO or Participating Provider Program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

(5) **Medicare Part D (Prescription Drug Coverage).** This integration will not apply to persons eligible for Medicare Part D whether or not actually enrolled in Medicare Part D. No benefits will be available for Prescription Drug expenses under this Plan.

Allowed Charges for Medicare integration only will be based on the following:

(1) If the Provider accepts Medicare assignment of benefits, the Allowed Charges will be the same fees allowed by Medicare.
(2) If the Provider does not accept Medicare assignment, the Allowed Charges will be based on the Usual, Reasonable and Customary Charges for Out-of-Network Providers, the Network allowance for Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.
(3) If the Provider provides services under a Medicare Private Contract Option, Allowed Charges will be based on the Usual, Reasonable and Customary Charges or the Participating Provider Network allowance, if applicable for services covered by this Plan.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option, the Provider’s charges can exceed the Medicare allowable fees.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Plan Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on

account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

An eligible domestic partner and same gender spouse is allowed the same rights as an opposite gender spouse for covered services under this Plan. While there is no provision for domestic partners or same gender spouses under the terms of the federal COBRA regulations, the Plan Sponsor allows domestic partners and same gender spouses to COBRA-like rights, and are therefore included in this COBRA section as eligible for continuing coverage following certain qualifying events.

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Members and their families covered under The Research Foundation for the State University of New York Graduate Student Employee Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009. COBRA continuation coverage for the Plan is administered by The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009, 1.518.434.7080. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Member, the spouse of a covered Member, or a dependent child of a covered Member. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Member during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or dependent child of such a

covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or dependent child was a beneficiary under the Plan.

The term "covered Member" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Member is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner or same-gender spouse is not a Qualified Beneficiary. This gives the domestic partner or same-gender spouse the contractual rights outlined in this document, but does not extend statutory provisions to the domestic partner.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Member during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Member.

(2) The termination (other than by reason of the Member's gross misconduct), or reduction of hours, of a covered Member's employment.

(3) The divorce or legal separation of a covered Member from the Member's spouse.

(4) A covered Member's enrollment in any part of the Medicare program.

(5) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an employer from whose employment a covered Member retired at any time.

If the Qualifying Event causes the covered Member, or the covered spouse or a dependent child of the covered Member, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Member, or the spouse, or a dependent child of the covered Member, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Member does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the

extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Member portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Member who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

Is a covered Member or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Member,

(3) commencement of a proceeding in bankruptcy with respect to the Employer, or

(4) enrollment of the Member in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Member and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

ATTN: Human Resources, COBRA Unit
The Research Foundation for the State University of New York
P.O. Box 9
Albany, New York 12201-0009

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Member** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely 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 Members may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Member.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Member's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Member ends on the later of:

(a) 36 months after the date the covered Member becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Member's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered spouse, surviving spouse or dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of, and with respect to, both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Member) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Member's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage (except that, if the disability determination is received prior to the Qualifying Event, the determination must be provided to the Plan Administrator before the end of the COBRA election period). This notice should be sent to the Plan Sponsor.

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

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA

continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? if you exhaust your coverage under COBRA, you may be able to purchase insurance coverage on an individual basis from a local HMO or other insurance carrier. The benefits available will vary, but you will be able to have any pre-existing condition exclusions on the individual coverage waived when you provide proof of coverage under this plan (see page 8), as long as there is a gap of no more than 63 days between the time your coverage is exhausted under this plan and when you enroll for an individual plan.

Is COBRA Continuation Coverage Available to Domestic Partners and Children of Domestic Partners? A Domestic Partner is treated as a Qualified Beneficiary. This gives the Domestic Partner the contractual rights outlined in this document. While there is no provision for domestic partners under the terms of the federal COBRA regulations, the Plan Sponsor allows domestic partners COBRA-like rights, and are therefore included in this COBRA section as eligible for continuing coverage following certain qualifying events.

Is COBRA Continuation Coverage Available to Same Gender Spouses and Children of Same Gender Relationship? An eligible same-gender spouse is allowed the same rights as an opposite gender spouse for Covered Services under this Plan. While there is no provision for same-gender spouses under the terms of the federal COBRA regulations, the Plan Sponsor allows same-gender spouse COBRA-like rights, and are therefore included in this COBRA section as eligible for continuing coverage following certain qualifying events.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Research Foundation for SUNY or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan 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 Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The Research Foundation for the State University of New York Graduate Student Employee Health Plan is the benefit plan of The Research Foundation for the State University of New York which is the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for and amount of benefits (including determination of fact), to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims, which Claims Administrator shall then have the same legal discretionary authority to construe and interpret the terms and provisions of the Plan and to make determinations as to eligibility for, and the amount of, benefits provided under the Plan. In particular, the Claims Administrator shall have the authority to determine Medical necessity, and Usual, Reasonable, and customary Charges.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

(10) Ensure continuing compliance with the HIPAA Privacy and Security Regulation and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as amended.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

THE NAMED FIDUCIARY

A "named fiduciary" is the one named in the Plan. The named fiduciary of this Plan is The Research Foundation of the State University of New York. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Claims Administrator is **not** a fiduciary under the Plan to the extent it pays claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Member and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Members.

The level of any Member contributions will be set by the Plan Administrator. These Member contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Member or withheld from the Employee's pay through payroll deduction.

Benefits are self-funded by The Research Foundation for SUNY, from its general assets, and are paid directly from the Plan through the Claims Administrator. Claimants have no greater claims on funds than an unsecured creditor of the Research Foundation for SUNY.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains intentionally false information, or that you or your dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto,

such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid for that claim to you and/or a Provider. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

AMENDING AND TERMINATING THE PLAN

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

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), U.S. Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

HIPAA COMPLIANCE

The federal Health Insurance and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information (also known as "protected health information" or "PHI"). A description of a Covered Person's HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Member covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Covered Person. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's Privacy Officer at the Employer.

The Employer will:

(1) not further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) ensure that any agents, including subcontractors and the Claims Administrator, to whom PHI is provided agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) not use or disclose PHI for employment-related actions and decisions;

(4) not use or disclose PHI in connection with any other benefit or employee benefit plan;

(5) report to the Plan or its designee any uses or disclosures of PHI that the Employer becomes aware of and is inconsistent with the uses or disclosures provided for in this Certification;

(6) make available the PHI available to an individual based on HIPAA's access requirements;

(7) make available the PHI for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;

(8) make available the information required to provide an accounting of disclosures in accordance with HIPAA's requirements;

(9) make its internal practices, books, and records relating to the uses and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services to determine compliance with HIPAA;

(10) ensure adequate separation between the Plan and the Employer in accordance with HIPAA by including the following in the Plan Documents: (1) describing in the Plan document those employees or classes of employees or other persons under control of the Plan Sponsor that will be given access to PHI, provided that any employee or person who receives PHI relating to payment under health care operations of or other matters pertaining to the Plan in the ordinary course of business must be included in such description; (b) restrict access to and use by such employees an other persons to the Plan administration functions that Plan Sponsor performs for the Plan; (c) provide an effective mechanism for resolving any issues of noncompliance with the Plan by persons described in "(a)" above; and (d) any other requirement under HIPAA to ensure adequate separation;

(11) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor 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 uses and disclosures to those purposes that make the return of destruction infeasible.

The following is a list of employees, classes of employees or other persons described in (10)(a) above that are entitled to PHI:

Graduate Student Employee Health Plan administration staff;
Research Foundation for SUNY auditors;
Stop loss insurance brokers; or
Stop loss insurance carriers.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Members or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under a future health Plan, if a Member or dependent has Creditable Coverage from this plan. The Member or

dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge upon written request, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Members. The Plan is insured for catastrophic losses.

PLAN NAME: The Research Foundation for the State University of New York Graduate Student Employee Health Plan

PLAN NUMBER: 512

TAX ID NUMBER: 14-1368361

PLAN EFFECTIVE DATE: August 15th, 1994

PLAN RESTATEMENT DATE: August 15th, 2013

PLAN YEAR ENDS: August 14th

EMPLOYER INFORMATION: The Research Foundation for the State University of New York, P.O. Box 9, Albany, NY 12201-0009, Tel. #: 1.518. 434.7080

PLAN ADMINISTRATOR: The Research Foundation for the State University of New York, P.O. Box 9, Albany, NY 12201-0009, Tel. #: 1.518. 434.7080

NAMED FIDUCIARY: The Research Foundation for the State University of New York, P.O. Box 9, Albany, NY 12201-0009, Tel. #: 1.518. 434.7080

AGENT FOR SERVICE OF LEGAL PROCESS: General Counsel, The Research Foundation for the State University of New York, P.O. Box 9, Albany, NY 12201-0009, Tel. #: 1.518.434.7045

CLAIMS ADMINISTRATOR:

MEDICAL
POMCO
2425 James Street
Syracuse, New York 13206
1.866.317.2098

PRESCRIPTION DRUGS
Express Scripts
P.O. Box 14711
Lexington, KY 40512
1.800.818.6632

SUMMARY OF MATERIAL MODIFICATIONSAMENDMENT
TO
THE RESEARCH FOUNDATION FOR THE STATE UNIVERSITY
OF NEW YORK GRADUATE STUDENT EMPLOYEE HEALTH PLAN

To: All Plan Participants and Beneficiaries of the Research Foundation for The State University of New York Graduate Student Employee Health Plan

This notice, called a 'Summary of Material Modifications," advises you of changes to your coverage under the Plan listed above. Please read this notice carefully and if you have any questions, please contact the Plan Administrator.

Keep this notice with your Plan Document/Summary Plan Description and make a note in your MPD/SPD as to what sections have been changed so that upon looking for information you will be reminded that specific information has been changed.

Effective August 15, 2014
AMENDMENT NUMBER 2013- 001
TO
The Research Foundation for the State University of
New York Graduate Student Employee Health Plan

NATURE OF AMENDMENT:

Effective August 15, 2014:

To amend the Plan to comply with the federal PPACA, removing all references to Pre-Existing Conditions and to update the employee waiting period for coverage not to excceed 90 days.

To amend the Plan to clarify language for Termination of Coverage, Dialysis and Allowed Charges.

To include coverage of Routine Patient Costs associated with Clinical Trials, Out-of-Pocket limits will include deductible and copays,

To indicate PPACA's Health Insurance Marketplace.

To amend the Plan to include deductible and copays accrue towards the Out-of-Pocket limits .

Provision Affected:

1. **The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Eligibility Requirements for Employee Coverage and Termination of Coverage are amended to read as follows:**

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a SUNY graduate student employed by the Research Foundation for SUNY in a RF student title, whose work coordinates with education and training leading to the fulfillment of academic requirements, and receiving an annual salary of at least $4,122.00 ($158.54 bi-weekly), through the Research Foundation for SUNY payroll system, and appointed to a position for which it is anticipated that funds will be available for an appointment period of at least one semester and Employed in active pay status (graduate student Employees may be eligible for coverage during summer period even if not in active pay status). Hourly-paid employees are not eligible.

(2) is an international SUNY graduate student holding an F-visa or J-visa, who qualifies under the requirements of number (1) above. F-visa, and J-visa holders must also purchase medical evacuation and repatriation insurance through the SUNY Health Plan for International Students.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Claims Administrator for further details about the Certificate of Creditable Coverage.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Provisions Affected:

2. **The Section entitled SCHEDULE OF BENEFITS, subsection Deductibles/Copayments by Plan Participant is amended to read as follows and only the following gridlines are added to read as follows:**

DEDUCTIBLES/COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is

paid by the Plan for any Covered Charges. This Plan has additional benefit deductibles that are separate from the Plan Year deductible. Please refer to the Schedule of Benefits below for details. Each August 15th, a new deductible amount is required. *Deductibles do accrue toward the 100% maximum Out-of-Pocket limit.*

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. *Copayments do accrue toward the 100% maximum Out-of-Pocket limit.*

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered service, please refer to the sections entitled **Comprehensive Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.

Plan Features	In-Network Benefits	Out-of-Network Benefits
Out-of-Pocket (OOP Limit including Deductible, per Calendar year.	***$6,350 per person $12,700 per Family Unit***	***No limit***
	Out-of-Pocket limit does not apply to: *Prescription Drug Out-of-Pocket amounts, specific benefits as noted in the Schedule of Benefits, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts.* *Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.*	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.317.2098. See the section entitled Cost Management Services for details.

Service Type	In-Network Benefits	Out-of-Network Benefits
Clinical Trials (Excludes the Actual Clinical Trial)	*100% of Allowed Charges*	*Not Covered*
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	

Provisions Affected:

3. The Section entitled MEDICAL SERVICES AND SUPPLIES, subsection Clinical Trials, is added; and subsection Dialysis are amended to read as follows:

Clinical Trials (In-Network Only)

The Plan will allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Exception: Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient.

Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copayment and/or Coinsurance). Additional visits are allowed up to 150% of the current Medicare allowed amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations.

Benefits are available for Service or Supplies related to Outpatient kidney dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: *Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.*

Provision Affected:

4. **The Section entitled DEFINED TERMS, definitions; Allowed Charges, Clinical Trials, Routine Patient Costs and Qualified Individual are added. The definition of Genetic Information is removed.**

   Allowed Charge (or Allowed Expense, Allowed Fee) - The Usual and Reasonable Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered out-of-network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges.

   Exception: *When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered outpatient renal dialysis services are payable up to 150% of the current Medicare allowable amount for the Medicare region in which services were*

performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

***Approved Clinical Trial** - a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:*

- *Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;*
- *Study or trial conducted under FDA approved investigational new drug application;*
- *Drug trial exempt from FDA approved investigational new drug application;*
- *Or as amended by the federal Patient Protection and Affordable Care Act.*

***Qualified Individual** is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.*

***Routine Patient Costs** include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.*

Provision Affected:

5. The Section entitled Plan Exclusions (11) Experimental or Not Medically Necessary is amended to read as follows:

Care and treatment that is either Experimental/Investigational or not Medically Necessary except as mandated by federal law. .

6. The Section entitled Coordination of Benefits, subsection Benefit Plan Payment Order (3) is amended to read as follows:

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential balance billing for outpatient dialysis charges should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Provision Affected:

7. **The Section entitled CONTINUATION COVERAGE RIGHTS UNDER COBRA, only the following paragraphs are amended to read as follows:**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

An eligible domestic partner and same gender spouse is allowed the same rights as an opposite gender spouse for covered services under this Plan. While there is no provision for domestic partners or same gender spouses under the terms of the federal COBRA regulations, the Plan Sponsor allows domestic partners and same gender spouses to COBRA-like rights, and are therefore included in this COBRA section as eligible for continuing coverage following certain qualifying events.

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Members and their families covered under The Research Foundation for the State University of New York

Graduate Student Employee Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009. COBRA continuation coverage for the Plan is administered by The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009, 1.518.434.7080. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

In addition to COBRA continuation of coverage, there may be other coverage options for Employees and their families: *You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For further information, you may visit the website a www.healthcare.gov.*

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What is the election period and how long must it last? *The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account*

of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? *Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.*

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) *The last day of the applicable maximum coverage period.*

(2) *The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.*

(3) *The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Member.*

(4) *The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with* respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. *Please note that pre-existing condition exclusions are prohibited for the Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.*

(5) *The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).*

(6) *In the case of a Qualified Beneficiary entitled to a disability extension, the later of:*

> ***(a)*** *29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or*
>
> ***(b)*** *the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.*

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

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

ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA Continuation coverage? *if you exhaust your coverage under COBRA, you may be able to purchase insurance coverage on an individual basis from a local HMO or other insurance carrier. The benefits available will vary, but you will be able to have any pre-existing condition exclusions on the individual coverage waived when you provide proof of coverage under this plan (see page 8), as long as there is a gap of no more than 63 days between the time your coverage is exhausted under this plan and when you enroll for an individual plan. Please note that pre-existing condition exclusions are prohibited for the Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.*

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Members or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

The Member or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge upon written request, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

AMENDMENT NUMBER 001
TO
THE RESEARCH FOUNDATION FOR THE STATE UNIVERSITY OF NEW YORK GRADUATE STUDENT EMPLOYEE HEALTH PLAN

BY THIS AGREEMENT, The Research Foundation for the State University of New York Graduate Student Employee Health Plan, the medical plan (herein called the "Plan") is hereby amended as follows, effective August 15, 2014.

NATURE OF AMENDMENT:

Effective August 15, 2014:

To amend the Plan to comply with the federal PPACA, removing all references to Pre-Existing Conditions and to update the employee waiting period for coverage not to exceed 90 days.

To amend the Plan to clarify language for Termination of Coverage, Dialysis and Allowed Charges.

To include coverage of Routine Patient Costs associated with Clinical Trials, Out-of-Pocket limits will include deductible and copays,

To indicate PPACA's Health Insurance Marketplace.

To amend the Plan to include deductible and copays accrue towards the Out-of-Pocket limits .

Provision Affected:

1. **The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Eligibility Requirements for Employee Coverage, Effective Date of Member Coverage and Termination of Coverage are amended to read as follows:**

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a SUNY graduate student employed by the Research Foundation for SUNY in a RF student title, whose work coordinates with education and training leading to the fulfillment of academic requirements, and receiving an annual salary of at least $4,122.00 ($158.54 bi-weekly), through the Research Foundation for SUNY payroll system, and appointed to a position for which it is anticipated that funds will be available for an appointment period of at least one semester, and Employed in active pay status (graduate student Employees may be eligible for coverage during summer period even if not in active pay status). Hourly-paid employees are not eligible.

(2) is an international SUNY graduate student holding an F-visa or J-visa, who qualifies under the requirements of number (1) above. F-visa, and J-visa holders must also purchase medical evacuation and repatriation insurance through the SUNY Health Plan for International Students.

EFFECTIVE DATE

Effective Date of Member Coverage. A Member will be covered under this Plan as of the first day that the Member satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Member Requirement.

(3) The Enrollment Requirements of the Plan.

(4) A waiting period not to exceed 90 days.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Claims Administrator for further details about the Certificate of Creditable Coverage.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Provisions Affected:

2. The Section entitled SCHEDULE OF BENEFITS, subsection Deductibles/Copayments by Plan Participant is amended to read as follows and only the following gridlines are added to read as follows:

DEDUCTIBLES/COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. This Plan has additional benefit deductibles that are separate from the Plan Year deductible. Please refer to the Schedule of Benefits below for details. Each August 15th, a new deductible amount is required. *Deductibles do accrue toward the 100% maximum Out-of-Pocket limit.*

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. *Copayments do accrue toward the 100% maximum Out-of-Pocket limit.*

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered service, please refer to the sections entitled **Comprehensive Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Out-of-Pocket (OOP Limit including Deductible, per Calendar year.	***$6,350 per person*** ***$12,700 per Family Unit***	***No limit***
	Out-of-Pocket limit does not apply to: *Prescription Drug Out-of-Pocket amounts, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts.* *Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.*	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.317.2098. See the section entitled Cost Management Services for details.		
Service Type	**In-Network Benefits**	**Out-of-Network Benefits**
Clinical Trials (Excludes the Actual Clinical Trial)	*100% of Allowed Charges*	*Not Covered*
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	

Provisions Affected:

3. **The Section entitled MEDICAL SERVICES AND SUPPLIES, subsection Clinical Trials, is added; and subsection Dialysis are amended to read as follows:**

Clinical Trials (In-Network Only)

The Plan will allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Exception: Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient.

Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copayment and/or Coinsurance). Additional visits are allowed up to 150% of the current Medicare allowed amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations.

Benefits are available for Service or Supplies related to Outpatient kidney dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: *Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.*

Provision Affected:

4. **The Section entitled DEFINED TERMS, definitions; Allowed Charges, Clinical Trials, Routine Patient Costs and Qualified Individual are added. The definition of Genetic Information is removed.**

Allowed Charge (or Allowed Expense, Allowed Fee) - The Usual and Reasonable Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered out-of-network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges.

Exception: *When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered outpatient renal dialysis services are payable up to 150% of the current Medicare allowable amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.*

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Approved Clinical Trial *- a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:*

- *Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;*
- *Study or trial conducted under FDA approved investigational new drug application;*
- *Drug trial exempt from FDA approved investigational new drug application;*
- *Or as amended by the federal Patient Protection and Affordable Care Act.*

Qualified Individual *is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.*

Routine Patient Costs *include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.*

Provision Affected:

5. The Section entitled Plan Exclusions (11) Experimental or Not Medically Necessary is amended to read as follows:

Care and treatment that is either Experimental/Investigational or not Medically Necessary except as mandated by federal law.

6. The Section entitled Coordination of Benefits, subsection Benefit Plan Payment Order (3) is amended to read as follows:

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential balance billing for outpatient dialysis charges should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Provision Affected:

7. **The Section entitled CONTINUATION COVERAGE RIGHTS UNDER COBRA, only the following paragraphs are amended to read as follows:**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

An eligible domestic partner and same gender spouse is allowed the same rights as an opposite gender spouse for covered services under this Plan. While there is no provision for domestic partners or same gender spouses under the terms of the federal COBRA regulations,
the Plan Sponsor allows domestic partners and same gender spouses to COBRA-like rights, and are therefore included in this COBRA section as eligible for continuing coverage following certain qualifying events.

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Members and their families covered under The Research Foundation for the State University of New York

Graduate Student Employee Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009. COBRA continuation coverage for the Plan is administered by The Research Foundation for the State University of New York, P.O. Box 9, Albany, New York 12201-0009, 1.518.434.7080. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

In addition to COBRA continuation of coverage, there may be other coverage options for Employees and their families: *You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For further information,* ***y****ou may visit the website a www.healthcare.gov.*

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What is the election period and how long must it last? *The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.*

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? *Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.*

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) *The last day of the applicable maximum coverage period.*

(2) *The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.*

(3) *The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Member.*

(4) *The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with* respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. *Please note that pre-existing condition exclusions are prohibited for the Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.*

(5) *The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).*

(6) *In the case of a Qualified Beneficiary entitled to a disability extension, the later of:*

(a) *29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or*

(b) *the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.*

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA Continuation coverage? *if you exhaust your coverage under COBRA, you may be able to purchase insurance coverage on an individual basis from a local HMO or other insurance carrier. The benefits available will vary, but you will be able to have any pre-existing condition exclusions on the individual coverage waived when you provide proof of coverage under this plan (see page 8), as long as there is a gap of no more than 63 days between the time your coverage is exhausted under this plan and when you enroll for an individual plan. Please note that pre-existing condition exclusions are prohibited for the Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.*

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Members or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

The Member or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge upon written request, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

AMENDMENT NUMBER 2013- 002
TO
THE RESEARCH FOUNDATION FOR THE STATE UNIVERSITY OF NEW YORK GRADUATE STUDENT EMPLOYEE HEALTH PLAN

BY THIS AGREEMENT, The Research Foundation for the State University of New York Graduate Student Employee Health Plan, the medical plan (herein called the "Plan") is hereby amended as follows, effective as of 8/15/2015.

NATURE OF AMENDMENT: To amend the Plan to indicate that the Plan will determine member status in accordance with the Patient Protection and Affordable Care Act's Employer Responsibility Mandate, to update the annual stipend minimum, to add an Out-of-Pocket maximum for prescription drugs (and this maximum cannot exceed limits established per the Patient Protection Affordable Care Act combined with medical Out-of-Pocket maximum), to update the Preventive Care language, to limit smoking cessation drugs/products to 180 days per Calendar Year, and to increase the preferred and Non-preferred Brand prescription copays.

Provision Affected:

1. The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Eligibility Requirements for Employee Coverage is amended to read as follows:

(1) is a SUNY graduate student employed by the Research Foundation for SUNY in a RF student title, whose work coordinates with education and training leading to the fulfillment of academic requirements, and receiving an annual salary of at least *$4,293.00* (*$165.12* bi-weekly), through the Research Foundation for SUNY payroll system, and appointed to a position for which it is anticipated that funds will be available for an appointment period of at least one semester, Employed in active pay status (graduate student Employees may be eligible for coverage during summer period even if not in active pay status) *and not to exceed 30 hours per week.* Hourly-paid employees are not eligible.

2) is an international SUNY graduate student holding an F-visa or J-visa, who qualifies under the requirements of number (1) above. F-visa, and J-visa holders must also purchase medical evacuation and repatriation insurance through the SUNY Health Plan for International Students.

You may continue coverage during the summer period, even if you are not actively a graduate student Employee, under the following circumstances:

(1) You were covered by the Plan throughout the preceding semester.

(2) The Operations Manager for the Research Foundation for SUNY at your campus certifies that you are expected to be re-appointed in the fall.

(3) You pre-pay the entire Employee share of the premium for the summer period.

Eligible Classes of Fellows. A scholar who is receiving non-wage payments from the Research Foundation for SUNY in support of academic study or fellow-initiated research and meets the eligibility requirements of the Research Foundation for SUNY. The Fellow must receive an annual stipend of at least *$4,293.00* for Plan Year *8/15/15 -8/14/16* to be eligible.

Provision Affected:

2. The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Termination of Coverage, When dependent Coverage Terminates is amended to read as follows:

When Dependent Coverage Terminates. A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or dependent coverage under the Plan is terminated.

(2) The date that the Member's coverage under the Plan terminates for any reason including death. (See Survivor Spouse; Continuation Coverage Rights under COBRA.)

(3) The date a covered spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)

(4) On the *last day of the month* that a dependent child ceases to be a dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Provision Affected:

3. The Section entitled SCHEDULE OF BENEFITS, the following grid lines only are amended to read as follows:

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered service, please refer to the sections entitled **Comprehensive Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
***Medical* Out-of-Pocket (OOP Limit including Deductible *and Medical Copayments*, per Calendar year**	**$*5,080* per person** **$*10,160* per Family Unit**	**No limit**
	Out-of-Pocket limit does not apply to: Prescription Drug Out-of-Pocket amounts, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts. Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.317.2098. See the section entitled Cost Management Services for details.		
Service Type	**In-Network Benefits**	**Out-of-Network Benefits**
• ***Tobacco* Cessation Counseling**	100% of Allowed Charges	Not a Benefit
	Limited to two individual tobacco cessation counseling attempts per Plan Year will be covered. Each attempt may include a maximum of four intermediate or intensive sessions. The Plan Year benefit will cover up to eight sessions for Covered Persons who use tobacco.	

Provision Affected:

4. The Section entitled SCHEDULE OF BENEFITS, subsection Prescription Drug Benefit is amended to read as follows:

<table>
<tr><th>Covered Drugs and Supplies</th><th>Limits and Copayments</th></tr>
<tr><td>Legend drugs (drugs obtainable only by prescription) for treatment of Illness or Injury.
Diabetic Medications (including Insulin).
Insulin Injections.
Insulin Syringes.
Note: list is not complete</td>
<td rowspan="6">Student Health Center
$7 copay when filled at the Student Health Center. Balance at 100% of preferred allowance.
$28 copay for Prescription Drugs to be used during the Summer period (120 day maximum) when filled at the Student Health Center. Balance at 100% of preferred allowance.

Network or mail order Pharmacy

<u>30 day supply</u>:
Generic Drug -$5 copay
preferred Brand Name Drug-$25 copay*
Non-preferred Brand Name Drug- $45 copay*

<u>90 day mail order</u>:
Generic Drug -$5 copay
preferred Brand Name Drug-$50 copay*
Non-preferred Brand Name Drug- $90 copay*

*When filled at an Express Scripts participating Pharmacy. (If a Brand Name Drug is purchased when a Generic is available, insured is responsible for the difference in cost between Generic and name Brand Name Drug, plus the copay).

Prescription Drug Out-of-Pocket Limit:
$1,270 per person
$2,540 per Family Unit

Out-of-Pocket limit does not apply to: Medical Out-of-Pocket amounts and any Plan penalties.

Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.

Out-of-Network Pharmacy:
Prescription Drugs are reimbursed up to the amount the program would reimburse a Network Pharmacy for that prescription. If the prescription was filled with a preferred Brand Name Drug or non-preferred Brand Name Drug that has a Generic equivalent, the program will reimburse up to the amount it would reimburse a Network Pharmacy for filling the prescription with the Generic equivalent.
Claims must be submitted to Express Scripts via paper claim for reimbursement.</td></tr>
<tr><td>Exclusions:</td></tr>
<tr><td>Growth hormones, narcolepsy drugs, anabolic steroids, anorexients, anti-rejection drugs, fertility agents, flouride, impotency drugs, injectable (all injectable unless otherwise noted),
IV injectable, multivitamins, immunization agents, cosmetic drugs, syringes other than for diabetes, and biological agents (blood and blood products).
Note: list is not complete</td></tr>
<tr><td>Your Doctor may be able to help you save money by prescribing Generic and preferred Brand Name Drugs if appropriate.

You may obtain a list of preferred Brand Name Drugs at www.express-scripts.com , or call Express Scripts at 1.800.818.6632 if you have any questions.</td></tr>
<tr><td>Exception: The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No copayment is required. Contact Express Scripts Customer Service department at 1.800.818.6632 for details.</td></tr>
</table>

Provision Affected:

5. The Section entitled MEDICAL SERVICES AND SUPPLIES, subsection Preventive Care is amended to read as follows:

Preventive Care

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act. The following is a list of the most common services. This list is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force; evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration; and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within the first Plan Year after one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service. Ancillary charges associated with any preventive care service will be available at no cost share. Please see www.HealthCare.gov/center/regulations/prevention.html for a complete listing and frequencies, unless listed in the Summary of Benefits.

Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness.

Provision Affected:

6. The Section entitled MEDICAL SERVICES AND SUPPLIES, subsection Preventive Care, (9) is amended to read as follows:

(9) ***Tobacco*** **Cessation Counseling (In-Network only benefit).** Two individual tobacco cessation counseling attempts per Calendar Year will be covered. Each attempt may include a maximum of four intermediate or intensive sessions. The annual benefit will cover up to eight sessions for Covered Persons who use tobacco.

Provision Affected:

7. The Section entitled PRESCRIPTION DRUG BENEFITS, the following subsection is added to read as follows:

Out-of-Pocket Limit

Covered expenses are payable at the percentage shown each Calendar Year until the Out-of-Pocket shown in the Schedule of Benefits is reached. Then, covered Prescription Drug Expenses Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the remainder of the Calendar Year.

Provision Affected:

8. The Section entitled PRESCRIPTION DRUG BENEFITS, subsection Covered Prescription Drugs, (4) is amended to read as follows:

(4) Prescription smoking cessation and preventive medications are covered as required under the federal Patient Protection and Affordable Care Act. If these standards change, the Plan will automatically cover the new recommended standards.

The Plan will comply within one year of the effective date of all new recommendations or guideline changes; the Plan will not cover any item or service that is no longer a recommended preventive service. No copayment is required for the following:

- Aspirin when prescribed by a Physician, limited to males ages 45 years through 79 years to reduce risk of myocardial infarction and to females ages 45 years through 79 years to reduce risk of ischemic stroke.

- Vitamin supplements when prescribed by a Physician for over the counter and prescription forms of folic acid for females to age 50 years who are planning or capable of Pregnancy; iron (ferrous sulphate) supplements to age one year for children who are at increased risk of iron deficiency anemia; and fluoride for children to age five years.

- Tobacco use cessation agents when prescribed by a Physician for Covered Persons over age 18 for over the counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents. *Coverage is limited to 180 days* per Covered Person per Plan Year.

- FDA approved contraceptives when prescribed by a Physician for females with reproductive capacity to include Generic Drug oral contraceptives, patches, and emergency contraceptives. Covered Brand Name contraceptives are subject to the Brand Name Copayments shown in the Schedule of Benefits if a Generic Drug version of the drug is available. **Exception:** If a Generic Drug version would not be medically appropriate for the patent as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts. Over the counter emergency contraceptives are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs.

- Vitamin D2 or D3 containing 1,000IU or less per dosage form or combination vitamin D products that also contain calcium (combination of two agents only for the combination) when prescribed by a Physician, limited to Covered Persons age 65 years or older.