Rensselaer Health Plan
Summary Plan Description
Your guide to the Rensselaer Health Plan benefits on the Point-of-Service and Traditional Plan
THE RENSSELAER HEALTH PLAN

Effective January 1, 2018

This booklet describes the benefits in effect as of January 1, 2018, under the Rensselaer Polytechnic Institute Health Benefits Plan for Active Employees and Retired Employees. The Plan is also commonly referred to as the Rensselaer Health Plan.

This document is intended to comply with the ERISA Summary Plan Description requirements. Rensselaer Polytechnic Institute fully intends to maintain the Plan. However, it reserves the right to terminate, suspend, discontinue, modify, or amend the Plan at any time upon advance notice to all Participants.

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION—Plan Overview</td>
<td>2</td>
</tr>
<tr>
<td>SECTION ONE—Definitions</td>
<td>6</td>
</tr>
<tr>
<td>SECTION TWO—How The Plan Works</td>
<td>7</td>
</tr>
<tr>
<td>SECTION THREE—Who Is Covered</td>
<td>10</td>
</tr>
<tr>
<td>SECTION FOUR—Deductibles, Maximums, and Penalties</td>
<td>11</td>
</tr>
<tr>
<td>SECTION FIVE—Inpatient Care</td>
<td>13</td>
</tr>
<tr>
<td>SECTION SIX—Outpatient Care</td>
<td>14</td>
</tr>
<tr>
<td>SECTION SEVEN—Rensselaer Health Plan Benefit Chart</td>
<td>16</td>
</tr>
<tr>
<td>SECTION EIGHT—Emergency Care</td>
<td>22</td>
</tr>
<tr>
<td>SECTION NINE—Home Health Care</td>
<td>23</td>
</tr>
<tr>
<td>SECTION TEN—Skilled-Nursing Facility Care</td>
<td>24</td>
</tr>
<tr>
<td>SECTION ELEVEN—Hospice Care</td>
<td>24</td>
</tr>
<tr>
<td>SECTION TWELVE—Private Duty Nursing</td>
<td>25</td>
</tr>
<tr>
<td>SECTION THIRTEEN—Prescription Drugs</td>
<td>25</td>
</tr>
<tr>
<td>SECTION FOURTEEN—Durable Medical Equipment, Prosthetics, Orthotics, and Hearing Aids</td>
<td>27</td>
</tr>
<tr>
<td>SECTION FIFTEEN—Vision Care</td>
<td>28</td>
</tr>
<tr>
<td>SECTION SIXTEEN—Exclusions</td>
<td>29</td>
</tr>
<tr>
<td>SECTION SEVENTEEN—Coordination of Benefits (COB) and Subrogation</td>
<td>31</td>
</tr>
<tr>
<td>SECTION EIGHTEEN—Termination of Coverage</td>
<td>35</td>
</tr>
<tr>
<td>SECTION NINETEEN—Continuation of Coverage (COBRA) and QMCSO</td>
<td>36</td>
</tr>
<tr>
<td>SECTION TWENTY—General Information and ERISA Guidelines</td>
<td>38</td>
</tr>
</tbody>
</table>

NOTICE

CDPHP Behavioral Health Access Unit
Telephone number for triage, prior authorizations, or questions: 1-888-320-9584
Fax number: (518) 641-3601

The line is staffed by clinical intake specialists weekdays from 8 a.m. to 6 p.m.
Nights, weekends, and holidays, a staff member is on call.
INTRODUCTION—Plan Overview

This booklet is intended to provide a Summary Plan Description of the Rensselaer Health Plan for all eligible Participants. Complete details can be found in the official Plan documents, which remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases. The Plan Administrator, Rensselaer Polytechnic Institute (also known as Rensselaer), retains exclusive authority and discretion to interpret the terms of the benefit plan described herein. The Plan is sponsored and maintained on a self-funded basis by Rensselaer.

As claims administrator of the Plan, Capital District Physicians’ Healthcare Network, Inc. (CDPHN) handles and processes all claims and performs claim-related functions. However, CDPHN has no underwriting liability for any of the benefits described in this booklet. The benefits described herein will be provided only to eligible employees of Rensselaer and their eligible dependents who are properly enrolled for these benefits.

Words That Are Used in This Booklet.

Although each is a component of the overall Rensselaer Health Plan, for convenience, Point-of-Service Medical Benefits will be referred to as “Point-of-Service Plan” or “POS Plan” and Rensselaer Polytechnic Institute Medical Traditional Plan will be referred to as “Traditional Plan.” The “Plan” will refer to the “Point-of-Service Plan” or to the “Traditional Plan.” Rensselaer will be referred to as “Employer,” Capital District Physicians Healthcare Network, Inc. will be referred to as “CDPHN.” The word “you,” “your,” “yours,” or “Participant” refers to you, the employee of RPI who is enrolled under the Plan, and to members of your family who are enrolled under the Plan. The “Primary Care Physician” or “PCP” refers to the physician you have selected from the CDPHN Network to manage your health care services.

Eligibility.

If you are a regular Rensselaer employee or a fixed-term employee with an appointment of at least 26 weeks and scheduled to work at least 40 hours per week or if you have an appointment of at least 52 weeks and scheduled to work at least 30 hours per week, you are eligible to participate in the Rensselaer Health Plan. You may enroll at any time within 30 days of your first day of employment to have coverage effective as of the first of the month following your date of hire. Eligible employees who do not enroll within the first 30 days of employment may enroll during “open enrollment” periods announced by Rensselaer (usually in November of each year) for coverage to be effective the following January 1. Eligible employees may add or remove eligible dependents within 30 days of certain qualified family status changes for the change in coverage to be effective as of the date of the change in family status. (Examples of family status changes include marriage, divorce, birth or adoption of a child, death of a dependent, or change in spouse’s employment.)

If you are a Rensselaer retiree, you are eligible to participate in the Rensselaer Health Plan, provided you are at least age 55 at separation, have completed at least five years of service with Rensselaer and retired directly from Rensselaer. Retiree participants age 65 and older are not eligible for the POS component of the Rensselaer Health Plan.

How Much Does Coverage Cost?

Rensselaer pays a significant portion of the cost and your share of the cost of coverage will be paid on a pre-tax basis under the Rensselaer Section 125 Plan.

The cost of coverage for eligible retirees is subsidized by Rensselaer up to a maximum of 50 percent (30 years of service) for retirees younger than 65. Retirees age 65 and older receive a flat dollar subsidy, with a maximum subsidy for 30 years of service. The amount of the Rensselaer subsidy for each eligible retiree is based upon the annual cost of coverage and the number of years of service the retiree rendered to Rensselaer prior to retirement. Rates are established and announced annually, and are effective each January 1. You can obtain current rates and information about payment methods by contacting Human Resources.

Point-of-Service Plan Components and How They Work.

The Rensselaer Health Plan is a managed-care plan in which a network of participating health care Providers renders preventive and sick care to eligible Plan Participants. Each time health care is required, eligible Plan Participants may choose to use a participating Network Provider for a preset fee (Copayment) or to go to any Provider outside the network and pay a greater share of the cost. Network Provider information is available at findadoc.cdphp.com. To enroll in the POS plan, you must live or work within the CDPHN service area. Note, post-65 Medicare eligible retirees are not eligible for the Rensselaer POS component. If you do not meet the POS requirements you may be eligible to enroll in the Traditional Plan (see page 4 for details).
The Primary Care Physician.

A Primary Care Physician (PCP) is the key to making the most of the Rensselaer Health Plan. When you enroll in the Plan, you should select a PCP from the CDPHN Network for yourself and one for each member of your family from the Provider directory.

Your PCP will provide routine care such as check-ups, treat illnesses that do not require a specialist, and coordinate all aspects of your health care by referring you to specialists and hospitals as needed. If, for any reason, you are not satisfied with your PCP, you are free to change to another PCP from the CDPHN Network as often as needed. You should, however, attempt to establish an ongoing relationship with your PCP.

Quality Health Care.

Care coordinated by your PCP ensures that one doctor has a complete picture of your health needs and medical history and is aware of all aspects of your health care. All participating physicians are carefully screened and subjected to periodic review by CDPHN. The education, experience, credentials, administrative procedures, and standard practices of all health care Providers are assessed carefully before they are admitted to the network. If you are now seeing a doctor who is not in the network, you should encourage your physician to contact CDPHN's Provider Services Department.

Freedom of Choice.

Every time you need health care, you may exercise your right to see any doctor you wish. You may choose a CDPHN Network provider or you may choose a provider that is not associated with the CDPHN network. If you decide on a doctor or facility outside the CDPHN network, (or see a Network Specialist Provider without a Referral from your PCP) you will receive benefits from the Plan for covered services; however you will pay a larger share of the costs, you will have to submit a claim with receipts for reimbursement, and you will have to meet a deductible (except for Emergency services, Vision hardware [frames & lenses] and Prescriptions, as these three categories are not subject to the Out-of-Network annual deductible).

In-Network or Out-of-Network?

If you decide to go to a CDPHN Network Provider, your services are rendered at the In-Network level of benefits. Depending on the service(s) you require, you may have to meet an annual deductible before the Plan pays benefits for the service. The In-Network annual deductible of $300/Individual and $600/Family per calendar year must be met in these instances. Once you have paid $300 out of pocket towards your Individual deductible (per Individual) or reached the cumulative $600 for your family, you will have met the deductible (Individual or Family) for the calendar year. From that point on, the services rendered by network providers will be either Covered in Full or subject to a Copayment.

However, if you decide to go to a non-participating provider, your services are rendered at the Out-of-Network level of benefits. Again, depending on the service(s) you require, you will likely have to meet an annual deductible before the Plan pays benefits for the service being rendered. The Out-of-Network annual deductible of $600/Individual and $1,200/Family per calendar year must be met in this instance. Once you have paid $600 out of pocket towards your Individual deductible (per Individual) or reached the cumulative $1,200 for your family, you will have met the deductible (Individual or Family) for the calendar year. From that point on, the services rendered by Out-of-Network providers will require that you pay 30 percent of Reasonable & Customary charges for each service except Emergency Services, Outpatient Mental Health, Outpatient Substance Abuse, Vision Hardware (frames & lenses) and prescriptions.

After you have met the Individual or Family deductible (as applicable) the plan will pay In-Network benefits or Out-of-Network benefits as defined on the benefit chart in Section Seven. You will pay the copay or coinsurance indicated and in the case of Out-of-Network services, you will pay any charge in excess of the Reasonable and Customary Charge as well.

Annual Out of Pocket Maximums.

No matter how large your medical health care costs may be in a given year for services covered under the Plan, your annual out-of-pocket maximum for medical and prescription expenses will not exceed $7,150/$14,300 (individual coverage/family coverage, respectively) for In-Network medical services and Out-of-Network medical services combined.

Note: Charges for services not covered under the Plan and charges determined to be in excess of Reasonable and Customer charges will continue to be your responsibility, even after the out-of-pocket maximum has been met.

Emphasis on Prevention.

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

When you need specialty care, your PCP coordinates your care with a participating network specialist. You pay an office visit copayment for each specialist visit. If you need specialty care that cannot be provided by a network specialist, the services are subject to prior written approval by the CDPHN Medical Director or his/her designee.

Traditional Plan—If You Live Outside the Area.

If you live outside the CDPHN service area, you still may join the Rensselaer Health Plan. Human Resources will let you know if you live beyond the reach of the network or if you are a post-65 Medicare-eligible retiree who lives within or outside the CDPHN service area; in which case, you will be eligible for benefits of the Traditional Plan. (The POS plan is not open to employees who do not live or work in the CDPHN Service Area or are post-65 Medicare-eligible retirees.)

Under the Traditional Plan, you will have to meet a Deductible of $300 per individual; or $600 for a family of three or more, before collecting benefits from the Plan. (Exceptions to deductible are those Traditional Plan benefits which indicate 100% coverage on the Rensselaer Health Plan Benefit Chart. See SECTION SEVEN, Traditional Plan.)

However, no matter how large your health care costs, your annual out-of-pocket maximum for medical and prescription expenses will not exceed $7,150 for individual coverage, or $14,300 for a family of three or more.

Although you will not benefit from the managed-care aspect of the Plan, you will be eligible for quality health-care coverage. Your Deductible and Coinsurance are more advantageous than if you lived in the area and chose Out-of-Network care on the Point-of-Service Plan. Claims for this Traditional Plan coverage are administered by CDPHN.

Prescription Drugs.

Participants in the Rensselaer Health Plan are able to purchase prescription drugs at all network pharmacies.

Point-of-Service Plan—the Plan provides In-Network benefits for prescription drugs that by law require a prescription, when prescribed by a Network Physician and obtained from a network pharmacy. A three-tier drug Copayment structure applies to prescriptions for up to a 34-day supply. Refer to SECTION SEVEN—Benefit Grid for prescription three-tier copayments. The plan provides Out-of-Network benefits of 70% of covered charges if the prescription is not written by a Network Provider or if the prescription is not filled at a participating pharmacy.

Traditional Plan—the Plan benefits cover prescription drugs at the same three-tier structure as mentioned for the POS Plan/In-Network Copayments. Refer to SECTION SEVEN—benefit grid for prescription three-tier copayments.

Prescriptions by Mail.

There also is a prescription mail service benefit for Participants of the Traditional Plan or the Point-of-Service Plan (In-Network and Out-of-Network) who take maintenance medication—medicine used to treat chronic conditions like high blood pressure, asthma or diabetes. These Participants may order up to a 90-day supply of maintenance drugs by mail for two (2) Tier 1, Tier 2, or Tier 3 drug Copayments, as applicable. A brochure describing the prescription drug program is available at Human Resources.

See SECTION THIRTEEN—Prescription Drugs for more detail.

When Does Coverage End?

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

- The last day of the month in which your employment ends;
- The last day of the month in which you cease to be an eligible employee or your dependent ceases to meet eligibility guidelines;
- The date you fail to make a required contribution; or
- The date the Plan is terminated.

Coverage for a dependent can terminate sooner if the dependent becomes an eligible employee under the Plan or the dependent no longer qualifies as an eligible dependent under the Plan. Some (but not all) of the events that cause coverage to terminate will allow you and/or your dependents, as applicable, to elect “COBRA” coverage for a period of time.

Refer to SECTION EIGHTEEN and NINETEEN—in this summary plan document for more details on Termination of Coverage and COBRA.
IMPORTANT

Please take time to read this booklet carefully so that you may get the most from your Rensselaer Health Plan.

- Only medically necessary health services are covered under the Plan, with the exception of certain preventive care services, (e.g., routine physicals, routine eye or hearing exams).
- POS Out-of-Network and Traditional Plan coinsurance and reimbursement is based on reasonable and customary charges.

A reasonable and customary charges means (i) a charge which is consistent with the charges of other Providers of a given service in the community in which the service is rendered, (ii) a charge fixed by law or (iii) a charge agreed upon by CDPHN and the Provider of the service. CDPHN shall have sole discretion to determine what is a reasonable and customary charge. A physician or other Provider may charge a Participant more or less than the reasonable and customary charge, but the Plan will not provide payment above the reasonable and customary charge. The Participant is responsible for all charges in excess of reasonable and customary.

- The fact that a physician or Provider has performed or prescribed a procedure or treatment, or that a procedure or treatment may be the only available treatment for a condition, does not mean the procedure or treatment is covered under the Plan. If you have any questions or need additional information about what is covered under the Plan, contact CDPHN Member Services at the telephone number on your ID card.
- The names of service Providers and the nature of the services provided may be changed from time to time, at the Plan claim administrator's discretion, and without prior notice or approval.
- It is important for you to follow the procedures described in this booklet and to give the claims administrator, CDPHN, all the information required under the Plan.
- Services rendered in conjunction with (or related to) a non-covered service are also not covered.

RENSSELAER HEALTH PLAN

A comparison of the various components of the Rensselaer Health Plan is set forth in the following chart. Detailed benefit information appears in SECTION FOUR through SECTION FIFTEEN.

<table>
<thead>
<tr>
<th></th>
<th>Point-of-Service In-Network</th>
<th>Point-of-Service Out-of-Network</th>
<th>Traditional Plan (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per visit fee</td>
<td>Deductible, then $20 PCP/ $35/Specialist Copayment. Deductible applies unless otherwise noted.</td>
<td>Covered services are subject to Deductible and Coinsurance</td>
<td>Covered services are subject to Deductible and Coinsurance</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$300/individual $600/family</td>
<td>$600/individual $1,200/family</td>
<td>$300/individual $600/family</td>
</tr>
<tr>
<td>Coinsurance rate</td>
<td>10% for certain services</td>
<td>30% after Deductible (2)</td>
<td>20% after Deductible (2)</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Deductible, then $300 IP Copayment</td>
<td>Deductible and 30% Coinsurance</td>
<td>Deductible, then $300 IP Copayment</td>
</tr>
<tr>
<td>MEDICAL and PHARMACY</td>
<td>$7,150/individual $14,300/family</td>
<td>$7,150/individual $14,300/family</td>
<td></td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Pre-existing conditions</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Pre-admission</td>
<td>NA</td>
<td>$400</td>
<td>$100</td>
</tr>
<tr>
<td>certification penalty (3)</td>
<td>Last day of the month in which age 26 is reached</td>
<td>Last day of the month in which age 26 is reached</td>
<td>Last day of the month in which age 26 is reached</td>
</tr>
</tbody>
</table>

(1) Membership in the Traditional Plan is limited to employees who live outside the network service area or are post-65 Medicare-eligible retirees. Human Resources will identify eligible employees.

(2) Coinsurance based on Reasonable and Customary (R&C) charges.

(3) Pre-admission certification penalty—Except in an Emergency, you must call CDPHN before confinement in a hospital or treatment center. Professionals at CDPHN review information received from you and your doctor before recommending which type of facility would be best for treatment. CDPHN then “precertifies” your hospital stay. If you do not call before admission, you are charged the pre-certification penalty. The penalty cannot be applied to your Deductible or to Out-of-Pocket Maximum.
SECTION ONE—Definitions

The following are definitions of terms used in the Plan. For your convenience words that are defined in this section appear throughout the document text with initial capitalization.

**Allowed Charge.** The Allowed Charge is the amount payable to participating providers as defined in provider contracts.

**CDPHN Medical Director.** The CDPHN Medical Director is a physician employed by CDPHN who has overall responsibility for the planning, supervision, and delivery of, and the determination of medical necessity for, medical care covered under the Plan.

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

**Coinsurance.** A percentage of the Allowed Charge you must pay for certain covered services after you satisfy the annual deductible (if applicable).

**Copayment.** A Copayment is a fixed amount you must pay for certain covered services you receive under the Plan, after you satisfy the annual deductible (if applicable).

**Deductible.** A Deductible is the amount of money you must pay toward covered charges before you are entitled to receive benefits from the Plan (certain benefits that are covered at 100% and may not be subject to Deductible).

**Emergency Care.** Emergency Care is care required because of a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in

- Placing the health of the person afflicted with such condition or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person, or
- Serious disfigurement of such person.

Examples of such Emergency situations are heart attacks, poisoning, and multiple traumas. Examples of conditions not considered to be Emergency situations are head colds, flu, tension headaches, toothaches, minor cuts, or bruises, or muscle strain.

**Illness.** A condition where the body fails to function normally due to physical or mental disorders or substance abuse.

**Injury.** Accidental physical harm to the body caused by unexpected external means.

**In-Network.** In-Network benefits are payments for services covered under the Plan rendered by a Network Provider, or otherwise specified under the Plan as In-Network benefits.

**Legal Guardian.** A Legal Guardian is a person who is appointed by an order of a court of competent jurisdiction to be the guardian of another person.

**Life Status Changes**: Life status changes include:

- Marriage, divorce or legal separation.
- Death of a spouse or eligible dependent.
- Birth or adoption of a child, or addition of an eligible dependent because of any other event (such as divorce or gaining custody of a child).
- Termination of your spouse’s employment.
- Changing from part-time to full-time employment status (or vice versa) by you or your spouse.
- Unpaid leaves of absence for you or your spouse.
- Significant change in the health coverage of you, or your spouse, attributable to an unexpected external means.

**Out-of-Network.** Services rendered by a non-Network Provider without a Referral from your Primary Care Physician. Also refers to the reduced level of benefit coverage the Plan provides for services rendered according to the Out-of-Network definition.

**Participant.** The employee and his/her enrolled dependents who are covered through the employer-sponsored Plan.

**Preauthorization or Prior Authorization.** Where noted in the Plan document, a Participant must obtain approval from CDPHN’s Resource Coordination Department before obtaining services.

**Precertification penalty.** A penalty imposed for certain Out-of-Network or Traditional Plan services if not Preauthorized by CDPHN when required. (E.g. facility charges related to inpatient hospitalization for Extended Care, Maternity, Transplants, etc.)

**Participating Practitioner:** Any licensed physician or medical professional who has agreed under contract with CDPHN to provide Health Services to Plan Participants. (Also referred to as a Participating Physician.)

**Participating Provider:** Any Hospital, Skilled Nursing Facility, Home Health Care agency, ambulance services laboratory or other health care facility or practitioner that has agreed under contract with CDPHN to provide Health Services to Participants.

**Primary Care Physician.** A Primary Care Physician (PCP) is a physician who has an agreement with CDPHN, to provide primary care to persons covered under the Plan. In order to receive benefits under the Plan, each person covered under the Plan should select a Primary Care Physician. With the exception of certain emergencies, you will be entitled to In-Network benefits under the Plan only when your Primary Care Physician provides services covered under the Plan or authorizes and provides a Referral to another Network Provider for services. A female Participant also may select an OB/GYN of record in addition to her Primary Care Physician.

**Provider.** A medical professional or facility that renders healthcare services. This includes physicians, hospitals, laboratories, etc.
Referral or Referral system. The Referral System is the system within managed care that ensures a Participant's medical care is coordinated. If a Primary Care Physician determines that a Participant needs services from a specialty participating practitioner, he/she will work with the Participant to select a network specialist and will coordinate care. When a participant receives services from a non-network provider, without prior approval from CDPHN, coverage may be denied.

Rehabilitation Facility. A Rehabilitation Facility is a hospital or other facility licensed to provide Rehabilitative Care.

Rehabilitative Care. Rehabilitative Care is care involved in the process of restoring a person's functional abilities after a disabling injury or illness. It does not include the maintenance of an achieved level of function.

Short-Term, Acute-Care General Hospital. A Short-Term, Acute-Care General Hospital is a licensed institution primarily engaged in providing: inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis; treatment or care of injured or sick persons by or under the supervision of physicians; and 24-hour nursing service by or under the supervision of registered nurses.

None of the following are considered Short-Term, Acute-Care General Hospitals:
- A division or unit of a Short-Term, Acute-Care General Hospital where the average length of stay is more than 30 days;
- Places primarily for nursing care;
- Skilled nursing facilities;
- Convalescent homes, health-related facilities or similar institutions;
- Institutions primarily for custodial care, rest, or as domiciles;
- Health resorts, spas, sanitariums, or tuberculosis hospitals;
- Infirmaries at schools, colleges, or camps; or
- Places for the treatment of alcoholism, or drug abuse, mental care, or rehabilitation.

Specialist Physician. A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine.

SECTION TWO—How The Plan Works

This booklet is the summary plan description for the Rensselaer Polytechnic Institute Health Benefits Plan for Active Employees and Retired Employees. The Plan is also referred to as the Rensselaer Health Plan. The Plan Administrator, Rensselaer Polytechnic Institute (Rensselaer), retains exclusive authority and discretion to interpret the terms of the benefit Plan described herein. The Plan is sponsored and maintained on a self-funded basis by Rensselaer.

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

Maximizing Your Benefits.

The Point-of-Service Plan has been designed to provide you with high quality medical benefits that also are affordable. When you use the managed-care system of Network Providers and Referrals, you will be responsible for a Deductible and/or a Copayment or Coinsurance for office visits and other In-Network services. When you use Out-of-Network Providers, you will be responsible for a higher Deductible and Coinsurance and any charges that exceed what the Plan covers (i.e., Reasonable and Customary Charges).

Less paperwork is another benefit of using the managed-care approach. When you receive services from a Network Provider, typically, the Provider will complete and submit claim forms to CDPHN and reimbursement will be paid directly to the Provider. If you use Out-of-Network Providers, in many instances, you will need to pay for the services and you will be responsible for mailing CDPHN a claim form and/or receipts for reimbursement.

Under The Plan You Can Receive Care in Two Ways.

In-Network benefits.

CDPHN has established a network of health care Providers who will provide health care services to persons covered under the Plan. When you receive covered services from a participating Network Provider your out-of-pocket costs will be less than if you received those services from a non-Network Provider. In order for you to receive In-Network benefits, your services MUST meet the requirements below:

- Services must be provided by a CDPHN participating network provider; or
- In the case of an Emergency, you receive care as described in SECTION EIGHT—Emergency care.

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

The Plan also provides Out-of-Network benefits so you can see any Provider you choose, even if he or she is not a Network Provider. If you receive care, which otherwise is covered under the Plan but does not meet ANY of the requirements for In-Network benefits described above, you will be entitled to receive Out-of-network benefits. Note that Out-of-Network benefits differ from In-Network benefits as you will be responsible for a greater portion of the cost, and in certain cases there may be no Out-of-Network coverage at all for a particular benefit. Refer to the benefit information contained within SECTION SEVEN—Rensselaer Health Plan Benefit Chart to determine the coverage available, and/or call CDPHN Member Services for clarification at the telephone number shown on your ID card.

**Medically Necessary Care.**

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

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

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

Examples of unnecessary care are:

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

In certain cases, your Primary Care Physician will make the *initial* decision as to whether care is medically necessary. In other cases, the CDPHN Resource Coordination Department will make the *initial* decision. The CDPHN Medical Director or his/her designee will make the *final* decision as to whether care is medically necessary.

In cases involving Network Providers, the CDPHN Medical Director, or his/her designee, may decide whether care is medically necessary at the time the care is proposed but *before* it is given to you. In cases involving non-Network Providers, the CDPHN Medical Director, or his/her designee, may decide *either before or after the care is given to you* that the care was not medically necessary. In those situations, you will be personally responsible for the cost of any care that the CDPHN Medical Director, or his/her designee, determines is, or was not, medically necessary.

Under the Traditional Plan, you will be personally responsible for the cost of any care that the CDPHN Medical Director determines is, or was not, medically necessary.

**Primary Care Physician Coordination.**

The Point-of-Service Plan Participants select one physician – a Primary Care Physician – to coordinate all health care needs provided in network. Primary Care Physicians provide medical care, maintain complete and accurate medical records, and coordinate care with specialists as appropriate. This means that one health care professional is responsible for knowing your complete medical history, and for assisting you in making well-informed health care decisions. You should contact your primary care physician before making any appointments for specialty care (other than OB/GYN, routine eye care, and dental visits). However, CDPHN does not require referrals.

**Credentialed Provider Network.**

The Point-of-Service Plan utilizes a network of health care professionals to provide your medical care. The network consists of highly qualified physicians and other medical professionals and facilities that work with you and your Primary Care Physician to keep you healthy, and provide quality care and treatment when you are ill or injured. The quality health care services provided must meet accepted high standards set by the national medical organizations and CDPHN. CDPHN uses a team of nurses who work with the CDPHN Medical Director, or his/her designee, and Network Providers to insure these quality health care guidelines are followed.

**Selecting Your Primary Care Physician.**

When you enroll in the Plan, you choose a Primary Care Physician for yourself and each enrolled member of your family from the list of Network Providers. A female Participant also may designate an OB/GYN of record. If you choose a new physician, an initial appointment should be made with that physician soon after your coverage is effective so that he/she may become familiar with your medical needs and start your medical record. Please notify CDPHN within five days of your first appointment to ensure current records and accurate claims processing.
Call your Primary Care Physician for all your health care needs. You may change your Primary Care Physician as often as necessary. However, because your Primary Care Physician coordinates your care, it is important to establish an on-going relationship and to change physicians only when necessary. To change your Primary Care Physician, call CDPHN Member Services at the telephone number shown on your ID card, or go to www.cdphp.com.

**Using the Referral System.**

An important part of managed care is the Referral. Care you receive from Providers other than your Primary Care Physician is coordinated by your Primary Care Physician to ensure that you are receiving the most appropriate medical treatment for your needs. This helps to prevent waste by reducing duplicate tests and procedures, which helps reduce medical costs.

*Whenever you go to a Network Provider other than your Primary Care Physician or designated OB/GYN of record, you are encouraged to coordinate care with your Primary Care Physician.* No special paperwork is required.

**Prior Authorization.**

Your physician must notify CDPHN’s Resource Coordination Department when he or she recommends hospitalization or services for, but not limited to, an inpatient hospital stay, skilled-nursing facility care, home health care, inpatient medical rehabilitation or mental health rehabilitation facility services, home dialysis, hospice care, and certain identified medicines, durable medical equipment (all rentals; and purchases over $500), or prosthetic devices over $500. Generally, your physician arranges prior authorization from CDPHN; however, *it is your responsibility to make sure that prior authorization is received, if required, before receiving a service.* In certain cases, a penalty applies if prior authorization is required but not obtained.

After review, CDPHN will notify the Participant, the Participant’s physician, and the hospital or facility that the care is determined to be medically necessary and appropriate. If it is determined that it is not medically necessary for the Participant to have the proposed services, CDPHN will contact the Participant and the physician with the determination.

**Reimbursement of Expenses.**

*Point-of-Service Plan, In-Network services.*

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

*Point-of-Service Plan, Out-of-Network services and Traditional Plan services.*

For health services received from non-Network Providers, claims for reimbursement must be submitted in accordance with the procedure set forth in SECTION TWENTY, under the paragraph heading Filing Claims.

**Timing of Submission.**

Claims for reimbursement submitted more than 90 days after the date the service or supply was received will not be paid under the Plan. CDPHN, in its sole discretion, may accept a late claim if extenuating circumstances prevented the Participant from making a claim within the 90-day period.

- Each Participant shall file with the Plan all pertinent information concerning himself/herself as CDPHN may require and in the manner and form as CDPHN specifies. The Participant shall not have any rights or be entitled to benefits unless he/she files the required information.
- Each Participant claiming benefits under the Plan shall supply written proof that the eligible expenses were incurred or that the benefit is covered under the Plan. Claim forms may be obtained from CDPHN; however you need not use a claim form if you supply the information noted above with the written proof of services rendered.
- If CDPHN determines that a Participant has not incurred a covered expense or that the benefit is not covered under the Plan or if the Participant fails to furnish the requested proof, no reimbursement shall be made to the Participant.

In the event of a question or dispute concerning coverage for health services, CDPHN may reasonably require that a physician designated by CDPHN examine a covered Participant at the Employer’s expense.

**Legal Action.**

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 90 days after the itemized bill or claim form and requested supporting information, if any, has been filed in accordance with the requirements of the Plan. Nor shall such action be brought after 12 months from the completion of health services for which payment recovery is sought.
SECTION THREE—Who Is Covered

Who is Covered Under the Plan?

If you are eligible and enrolled in one of the plans, you are covered. Also, your dependents described below are covered, if they are enrolled for coverage under the Plan you have selected:

- Your wife or husband, unless you are divorced, legally separated, or your marriage has been annulled. Proof of legal separation will be required upon request by the Plan Administrator.
- Your children who are younger than 26 years of age.
- Your children who are unable to work or support themselves because of mental illness, developmental disability, or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached age 19. A Network Primary Care Physician must certify the child's disability. In addition to this certification, CDPHN has the right to periodically check whether a child is and continues to qualify as an incapacitated child.

Other Children Covered Under the Plan.

In addition to your natural children, the following other children also are covered under the Plan if the child also meets the above tests for children covered under the Plan:

- A legally adopted child.
- A child for whom you are the Legal Guardian.
- A stepchild or foster child who lives with you and is dependent upon you for support.
- A child for whom you are the proposed adoptive parent, and who is dependent upon you during the waiting period prior to the adoption becoming final.
- Any other child who qualifies as a dependent for purposes of your federal income tax return.

Newborn Child.

Your newborn child will be covered from the date of birth, provided you apply for coverage of the child within 30 days of the newborn’s date of birth. If a child of yours who is covered under the Plan gives birth, that newborn grandchild will not be covered.

Adopted Newborn.

A. When The Plan will cover an Adopted Newborn from the Moment of Birth:

If you have family coverage under the Plan, or switch to family coverage (according to “Newborn Child” above), the Plan will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

- You (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth and
- You file a petition pursuant to 115-c of the New York State Domestic Relations Law within 30 days of the infant’s birth.

B. When The Plan will not cover Adopted Newborns from the Moment of Birth:

Notwithstanding the provisions of Paragraph “A” above, the Plan will not cover an adopted newborn from the moment of birth if one of the child’s natural parents has coverage available to cover the newborn’s initial hospital stay, or if a notice of revocation of the adoption has been filed, or one of the natural parents revokes their consent to the adoption. If the Plan provides benefits to cover an adopted newborn and the notice of the adoption is revoked or one of the natural parents revokes their consent, the Plan will be entitled to recover any sums paid for care of the adopted newborn.

Eligibility for Coverage.

You (and your eligible dependents described above) are eligible to participate in the Plan if you satisfy the eligibility rules described earlier in this document. Refer to INTRODUCTION—Plan Overview, “Eligibility.” Rensselaer determines eligibility without regard to an individual’s eligibility for Medicaid.
Changing Your Election during the Year.

Your election will normally stay in effect for the entire Calendar Year. However, you can change your coverage category during the year if you have a “Life Status Change” (refer to SECTION ONE—Definitions). Any change you make to your elections must be consistent with your Life Status Change. Also, you must complete and return an enrollment change form to Human Resources within 30 days of the date the status change occurs. As an exception, the enrollment change form may be returned up to the last day of the period for electing COBRA coverage, if the Life Status Change is also a qualifying event that allows your spouse, or a dependent child (or both) to elect COBRA coverage. Refer to SECTION NINETEEN—Continuation of Coverage (COBRA) and QMCSO.

Note: You will be allowed to change your election during the year for reasons other than a Life Status Change to the extent, and only to the extent, that you are allowed to change your pre-tax contributions for health plan coverage under the terms of Rensselaer’s Section 125 Plan as in effect from time to time. You may contact Human Resources for more information about the rules of the Section 125 Plan.

SECTION FOUR—Deductibles, Maximums, and Precertification Penalties

DEDUCTIBLES.

Annual In-Network Deductible.

The annual In-Network Deductible is the initial amount of covered In-Network expenses that is paid by the Plan Participant before any benefits are paid by the Plan for the service being rendered. Note: In-Network Deductibles are separate from Out-of-Network Deductibles. Services are rendered either In-Network or Out-of-Network and are applied to either the In-Network or Out-of-Network Deductible, as applicable. Not all benefits are subject to Deductible. The Plan provides benefits for those services that are not subject to Deductible without requiring that the Plan Participant has met the annual deductible. However, the Plan Participant is responsible for any applicable copayment or coinsurance. The annual Deductible starts over for each Participant, each Calendar Year (January 1 to December 31). There are two annual In-Network Deductibles, individual and family (see below).

Annual Out-of-Network Deductible.

The annual Out-of-Network Deductible is the initial amount of covered Out-of-Network (OON) medical expenses that is paid by the Participant before any OON benefits are paid by the Plan. The Deductible starts over for each Participant, each Calendar Year (January 1 to December 31)—thus the name annual Deductible. There are two annual OON Deductibles, individual and family (see below).

Individual Deductible.

An individual Deductible applies separately to you and each of your dependents covered by the Plan. Once a Participant’s Deductible is paid in a Calendar Year for either In-Network or Out-of-Network services, the Plan begins to pay benefits either In-Network or Out-of-Network, whichever deductible has been met, for that Participant. Note: ER, vision, and prescription expenses are not subject to Deductible.

The individual IN Deductible for the Point-of-Service Plan is $300.
The individual OON Deductible for the Point-of-Service Plan is $600.
The individual Deductible for the Traditional plan is $300.

Family Deductible.

A family Deductible is the most your family has to pay in Deductibles in a Calendar Year—regardless of how large your covered family. When the combined total of Deductibles paid for your covered family members equals the family Deductible amount, the Plan begins to pay benefits either In-Network or Out-of-Network, whichever deductible has been met, for each member of the entire family for the remainder of the Calendar Year. Note: ER, vision, and prescription expenses are not subject to Deductible.

The family IN Deductible for the Point-of-Service Plan is $600.
The family OON Deductible for the Point-of-Service Plan is $1,200.
The family Deductible for the Traditional plan is $600.

Note: If two or more covered family members are injured in the same accident, only one cash Deductible will have to be paid that year. This will cover the combined family expenses related to the accident.
**PENALTIES.**

**Precertification Penalty.**

A Precertification penalty applies to non-network inpatient facility charges (examples include inpatient hospital, medical rehabilitation or extended care).

**Point-of-Service Plan**—CDPHN Resource Coordination must precertify each Out-of-Network (OON) inpatient stay (except Emergencies and inpatient Mental Health and Substance Abuse detox). A $400 OON Precertification penalty applies if not precertified.

**Traditional Plan**—CDPHN Resource Coordination must precertify each inpatient stay (except Emergencies). A $100 Precertification penalty applies if not precertified.

**MAXIMUMS**

**Annual Out-of-Pocket Maximums.**

Once a Participant has paid an amount equal to their out-of-pocket maximum, the Plan will pay 100% of the Reasonable and Customary Charge for covered expenses. The Rensselaer Point-of-Service Plan tracks a Medical and Prescription out-of-pocket maximum. There is an individual maximum and a family maximum. Use the following grid to determine which maximum(s) apply to you and your dependents based on whether your coverage is individual or family. The Traditional Plan, as illustrated, also tracks a medical and prescription out-of-pocket maximum.

**Point-of-Service Plan, Annual Out-of-Pocket Maximum—Medical and Prescription Expenses:**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>In-Network and Out-of-Network Out-of-Pocket Expenses Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,150</td>
</tr>
<tr>
<td>Family of 3 or more</td>
<td>$14,300</td>
</tr>
</tbody>
</table>

**Traditional Plan, Annual Out-of-Pocket Maximum—Medical and Prescription Expenses:**

<table>
<thead>
<tr>
<th>Coverage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,150</td>
</tr>
<tr>
<td>Family of 3 or more</td>
<td>$14,300</td>
</tr>
</tbody>
</table>

**Note:**

- Participant Coinsurance payments for covered services are credited toward the out-of-pocket maximum.
- Participant Copayments (fixed visit fees) for covered services are credited toward the out-of-pocket maximum.
- Participant payments for covered services that apply to the annual Deductible are credited toward the out-of-pocket maximum.
- Participant Out-of-Network payments during 4th quarter of a Calendar Year that are credited to that Calendar Year Deductible also are credited to the following year’s Deductible. This is referred to as 4th Quarter Carryover and applies only to Out-of-Network expenses.
- Precertification penalties are not credited toward the out-of-pocket maximum.
- Participant payments in excess of the Reasonable and Customary or Allowed Charge are not credited toward the out-of-pocket maximum.
- Participant payments for services that are not covered by the Plan are not credited toward the out-of-pocket maximum.

**Lifetime Maximum Benefits.**

There are no lifetime maximum benefits on the Point-of-Service or the Traditional Plans.
SECTION FIVE—Inpatient Care

Medical Services While Hospitalized.

Under both the Point of Service Plan and Traditional Plan, benefits for medically necessary medical services while hospitalized due to accidental Injury, Illness, or pregnancy, including hospital visits, consultations, surgical operations, radiology, pathology, anesthesiology, chemotherapy, and inhalation therapy will be provided. Surgical operations include reconstructive surgery when such surgery is incidental to or following surgery resulting from trauma, infection, or other diseases of the part of the body involved, and reconstructive surgery performed on a covered dependent child because of a congenital disease or anomaly, which has resulted in a functional defect. Coverage is provided for breast reconstruction surgery after a mastectomy for all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined to be appropriate by the attending physician and the patient.

Under the Point-of-Service Plan.

During any period of hospitalization for which coverage is provided under the Plan, you also will be entitled to benefits for the services of your Primary Care Physician, or another Network Provider to whom you are referred by your PCP—if your admission was authorized by your PCP. If your admission was not authorized by your PCP, you will be entitled to Out-of-Network benefits for the services of a non-Network Provider.

Under the Traditional Plan.

During any period of hospitalization for which coverage is provided under the Plan, you also will be entitled to benefits for services of your physician.

Services Not Covered.

The Plan will not provide benefits for the following services in a hospital:

- Special duty nurses, unless in the sole judgment of the CDPHN Resource Coordination Department, private duty nurses are medically necessary for your condition;
- Private room, unless in the sole judgment of the CDPHN Resource Coordination Department a private room is medically necessary for your condition. If you occupy a private room without authorization, you will have to pay, in addition to Coinsurance, if any, the difference between the hospital’s charges for a private room and the hospital’s most common charge for semi-private accommodations;
- Non-medical items, such as television rental;
- Blood, blood products, blood plasma, packed blood cells, and blood platelets, when participation in a volunteer blood replacement program is available to you.

Benefits will be provided for any day the CDPHN Resource Coordination Department determines that hospitalization was medically necessary for the care or treatment of your condition, Illness, or Injury. Inpatient hospital maternity care is covered for at least 48 hours after childbirth for any delivery other than a cesarean section, and for at least 96 hours after cesarean section. The Plan participant has the option to be discharged earlier than the 48 or 96 hours. Benefits will not be provided after a date the CDPHN Resource Coordination Department determines that hospitalization no longer was medically necessary.

Benefits for inpatient hospital care follow:

A. Alcohol and Substance Abuse.

Benefits for inpatient hospitalization for alcohol and substance abuse care on POS and Traditional Plans are covered. Detoxification and rehabilitation services are included in inpatient coverage.

B. Mental Health.

Benefits for hospitalization for mental health care will be provided subject to the following conditions and limitations:

- The hospitalization is in a psychiatric unit of a Short-Term, Acute-Care General Hospital;
- The mental condition for which you were hospitalized is subject to clinical improvement;
- Hospitalization will not be provided for a condition that (1) has been exacerbated or prolonged by non-compliance or refusal of treatment, or (2) is for a behavioral condition due to organic mental disorders, mental retardation, or pervasive developmental disorders;
- Unlimited days per calendar year for treatment of medically necessary mental health conditions, including all facility, diagnostic, and physician’s charges.

C. Medical Rehabilitative Care.

Benefits for inpatient hospitalization for Rehabilitative Care will be provided subject to the following conditions:

- The hospitalization is in a Short-Term Acute Care General Hospital or Rehabilitation Facility.
- The hospitalization is primarily for Rehabilitative Care and is only for a condition that can be expected to result in the significant improvement of your condition.
- 60 days of medical rehab inpatient care, in-network and out-of-network combined, per calendar year. No day limits on the Traditional Plan.
**Payments for Inpatient Care.**

- **Under the Point-of-Service Plan.**
  After you pay the $300 Inpatient Copayment and meet the annual deductible, the Plan will pay In-Network benefits of 100% of the cost of covered medical services if your admission to a network hospital is prior authorized by CDPHN Resource Coordination.

  If your admission was not authorized by CDPHN Resource Coordination, the Plan will pay Out-of-Network benefits of 70% of the Reasonable and Customary Charge, after payment of the Deductible, for the covered medical services rendered during the hospital stay.

  Pre-admission certification penalty—prior to confinement in a hospital or treatment center, you must call CDPHN Resource Coordination. Professionals at CDPHN review information received from you and your doctor before recommending what type of facility would be best for treatment. CDPHN then “certifies” your hospital stay. If you do not call before admission, you are charged the pre-admission certification penalty of $400. The penalty cannot be applied to your Deductible. (Emergency situations are an exception to the Precertification penalty.)

- **Under the Traditional Plan.**
  The Plan will pay 100% of the Reasonable and Customary Charge, for the covered medical services rendered during the covered hospital stay, after the payment of the deductible then $200 Inpatient Copayment.

  Pre-admission certification penalty—before confinement in a hospital or treatment center, you must call CDPHN Resource Coordination. Professionals at CDPHN review information received from you and your doctor before recommending what type of facility would be best for treatment. CDPHN then “certifies” your hospital stay. If you do not call before admission, you are charged the pre-admission certification penalty of $100. The penalty cannot be applied to your Deductible. (Emergency situations are an exception to the Precertification penalty.)

**SECTION SIX—Outpatient Care**

**Outpatient Medical Services.**

**In-Network benefits.**

The Point-of-Service Plan provides In-Network benefits for covered outpatient medical services under the following conditions:

- Services must be provided by a CDPHN participating network provider;
- The service must be medically necessary;
- In the case of an Emergency, you receive care as described in SECTION EIGHT—Emergency Care.

Note: Under certain circumstances, the Plan may authorize care from non-Network Providers. For example, in the case of organ transplants, services may not be available from Network Providers. In such situations, care provided by a designated non-Network Provider will be covered at the In-Network level of benefits if the covered services are authorized by your Primary Care Physician and prior authorization is received from the CDPHN medical director, or his/her designee.

**Out-of-Network benefits.**

The Point-of-Service Plan provides Out-of-Network benefits for covered outpatient medical services if a non-Network Provider renders the service, or if a Network Provider without a Referral from the Primary Care Physician renders the service.

**Under the Traditional Plan.**

Benefits will be provided as described within for covered services when rendered by a physician or other practitioner or by a facility or other Provider licensed to provide the services rendered.

**Office Visits.**

The Plan will provide benefits for office visits to a CDPHN participating provider for treatment of illness, disease, and injury. No special paperwork is required, but you are encouraged to coordinate care with your PCP.

**Benefit Detail.**

Refer to the information above to differentiate In-Network and Out-of-Network guidelines. Refer below for detail on Preventive Care followed by an alphabetic list of selected outpatient medical services.


The Point-of-Service Plan provides benefits for preventive care services rendered by a CDPHN participating provider or by another Network Provider for whom your PCP provided a referral as described below:

- **Routine physical examinations (age 19 and above)**—no benefits are provided when care is rendered by a Non-Network Provider.
- **Well-child care**—services must be provided by child’s Plan PCP; no benefits are provided when care is rendered by a Non-Network Provider.

  **Visits by:** 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months and 36 months.

  Ages 3 to 19—one visit every year. Copay applies.

- **Routine Pap tests.** In-Network and Out-of-Network benefits apply.
- **Immunizations, including travel immunizations**—no benefits are provided when a Non-Network Provider renders care.
- **Routine Mammograms**—In-Network and Out-of-Network benefits apply.
- **Routine gynecological examination**—no benefits when rendered by a Non-Network Provider.
- **Routine eye examination**—one self-refer visit/calendar year. (Must be to a participating optometrist or ophthalmologist for In-Network benefits; POS Plan.)
- **Routine bearing examination**—one visit/calendar year. In-Network and Out-of-Network benefits apply.

The Traditional Plan provides benefits for the following preventive care services:

- **Routine physical examinations**—limited to one exam per calendar year. Related Routine Labs covered in full.
- **Preventive Well-child care**—related routine labs and immunizations covered in full. Frequency guidelines apply.
- **Routine gynecological examination**—related lab services billed as routine are covered in full.
- **Routine Mammograms.**
- **Routine Pap tests.**
- **Routine eye examination**—one visit/calendar year.
- **Routine bearing examination**—including examination by an audiologist; one visit/calendar year.
- **Immunizations**—Travel immunizations not covered.

**Accident Related Dental Services.** The Plan provides benefits for dental service required as a result of an accidental injury that occurs to sound natural teeth. Initial diagnosis of trauma must be diagnosed within 72 hours of the accidental injury. The service must be rendered within 12 months of the accident. Services include:

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

**Alcohol and Substance Abuse.** The Plan provides benefits for inpatient and outpatient treatment of Alcohol and Substance abuse. Refer to SECTION FIVE for inpatient services. See SECTION SEVEN for MH/SA Benefits.

**Ambulance Service.** The Plan will provide benefits for medically necessary transportation by ambulance to the nearest facility qualified to provide the required treatment. Air Ambulance is not covered. If, in the judgment of your PCP, emergency transport by ambulance within the CDPHN service area was required, 100% of covered charges applies.

**Autism.** The Plan has adopted the New York State Autism Mandate effective January 1, 2015. Applied Behavioral Analysis (ABA) services are covered under the behavioral health benefit. Prior authorization by CDPHN's Medical Director or his/her designee is required for some services.

**Blood.** The Plans provides benefits for blood, blood products, blood plasma, packed blood cells and blood platelets, *if participation in a volunteer blood replacement program is not available to you.* The Plan also will provide benefits for autologous (one’s own) blood collection and storage service when in conjunction with a scheduled surgical procedure.

**Chiropractic Services.** The Plan provides benefits for office visits to a chiropractor for medically necessary chiropractic care that the chiropractor is licensed to provide. Benefits for office visits to a chiropractor are limited to 20 visits (In-Network and Out-of-Network combined) in a calendar year. Lab services billed or ordered by a chiropractor are excluded. X-rays, supplies, and therapy are covered. Radiology may take separate copay.

**Diagnostic X-ray, Laboratory Examinations and other Outpatient Diagnostic Tests.** The Point-of-Service Plan will provide benefits for radiology, pathology, and medical testing (e.g. EKG, pulmonary studies, etc.) in connection with the treatment of Illness, Injury, or preventive care. The Traditional Plan provides benefits for radiology, lab services, and medical testing when medically necessary. Routine services are excluded on the Traditional Plan, except as defined on the following pages.

**Family Planning Services.** Family Planning counseling is not covered. IVF, GIFT, etc., artificial insemination, reversal of voluntary sterilization, and sperm banking are not covered. Sterilization is covered under the surgery benefit.

**Growth Hormone Therapy.** The Plan will provide benefits for Growth Hormone Therapy when deemed medically necessary.

**Infertility Services.** Infertility services are not covered. The Plan will, however, provide benefits for the diagnosis and treatment of a medical condition that results in infertility. Certain surgical and non-surgical procedures are not covered (See SECTION SIXTEEN—Exclusions). Infertility drugs are not covered.
Mental Health Care Visits. The Plan will provide benefits for outpatient mental health care visits. There is no visit limit. Refer to SECTION FIVE for inpatient services and limitations on inpatient hospital stays.

Office Visits. The Plan will provide benefits for office visits to a physician for the treatment of Illness, disease, Injury, or a condition. For this Plan, a split copayment applies—$20 PCP/OB/GYN copayment/$35 Specialist copayment for services rendered other than a PCP or OB/GYN.

Note: If a service is specifically covered under another Paragraph of this SECTION SIX, it will be covered under the provisions of the other paragraph, and not under the provisions of this paragraph, even though the service was given as part of an office visit.

Prenatal and Postnatal Maternity Care. The Plan provides benefits for prenatal and postnatal outpatient care. Charges for delivery of the newborn (including delivery and complications rising from pregnancy, if any) are covered. Inpatient hospital care is covered for at least 48 hours after childbirth for any delivery other than a cesarean section, and for at least 96 hours after cesarean section. The member shall have the option to be discharged earlier than the 48 or 96 hours.

Second Surgical Opinion. The Point of Service Plan provides benefits for a second surgical opinion when your Primary Care Physician or another Network Provider with a referral from your PCP recommends that surgery be performed. Under the Traditional Plan, benefits will be provided for a second surgical opinion when your physician recommends that surgery be performed. Benefits for second surgical opinion are subject to the following conditions:

- The second surgical opinion on an inpatient or outpatient procedure is rendered by a physician who is a board certified specialist and who by reason of his/her specialty is determined by the Plan to be an appropriate physician to consider the surgical procedure being proposed; and
- The second surgical opinion is rendered with respect to an inpatient or outpatient surgical procedure of a non-emergency nature for which benefits would be provided under the Plan if such surgery were performed.

Surgery (Outpatient or Office). The Plan will provide benefits for outpatient (ambulatory) surgery, or surgery in a physician’s office including anesthesia.

SECTION SEVEN—Rensselaer Health Plan Benefit Chart

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Dental</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment. Coverage for accidental injury to sound teeth within 12 months of the accident.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Coverage for accidental injury to sound teeth within 12 mos. of the accident.</td>
</tr>
<tr>
<td>Allergy Immunotherapy</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment. Allergy vials: No copayment. No deductible. No coinsurance.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Deductible, then covered in full.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Deductible, then covered in full. Air ambulance not covered.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Air ambulance not covered.</td>
</tr>
<tr>
<td>Anesthesia—IP/OP/Office</td>
<td>Deductible, then covered in full.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Blood IP/OP</td>
<td>Deductible, then covered in full.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Cardiac Rehab—Prior authorization after 36th visit required IN and OON.</td>
<td>Deductible, then covered in full/OP; Deductible then $20 PCP/$35 Specialist copayment/office. No visit maximum.</td>
<td>Deductible then 30% coinsurance to OOP maximum. No visit maximum.</td>
</tr>
<tr>
<td>Chemotherapy, Inhalation &amp; Radiation Therapy—Facility &amp; Physician.</td>
<td>Deductible, then covered in full.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Deductible, then $35 Specialist copayment. Limit 20 visits/calendar year. Combined INN/OON. Lab services not covered. Radiology takes separate copay.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Limit 20 visits/calendar year. Combined INN/OON. Lab services not covered. Radiology takes separate copay.</td>
</tr>
<tr>
<td>Colorectal Screenings</td>
<td>Routine: No copayment. No deductible. Non-Routine: Deductible then $20 PCP/$35 Specialist Copayment</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental—Routine</td>
<td>Contact Delta Dental 1-800-932-0783 Group Dental Claims.</td>
<td>Contact Delta Dental 1-800-932-0783 Group Dental Claims.</td>
</tr>
<tr>
<td>1. DME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Diabetic Drugs/Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Self-Management Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Dialysis &amp; Hemodialysis— Facility &amp; Physician—Hospital, Freestanding Facility, Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Deductible, then covered in full. Prior authorization from Resource Coordination required for Home Dialysis.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Routine foot orthotics excluded. Foot orthotics covered if medically necessary. Prior authorized from Resource Coordination for all rentals and for purchased items over $500.</td>
</tr>
<tr>
<td>Includes Prosthetics, Orthotics and Medical Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (Facility Charges) COVERED—YES</td>
<td>$100 copayment, then covered in full for visit to ER. (No Deductible). Copayment waived if admitted within 24 hours.</td>
<td>Covered in full, No Deductible—if emergency. Deductible then 30% coverage to OOP Maximum, if non-emergency or not rendered within 48 hours.</td>
</tr>
<tr>
<td>Emergency Room (Physician Charges) COVERED—YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$35 copayment (Deductible waived). Limit to 1 self-referral/calendar year to par optometrist or ophthalmologist. Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>1. Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Frames/Lenses/Contacts</td>
<td>100% charges up to the maximum benefit. Deductible waived. See SECTION FIFTEEN—Vision Care</td>
<td>100% charges up to the maximum benefit. Deductible waived. See SECTION FIFTEEN—Vision Care</td>
</tr>
<tr>
<td>1. Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Deductible, then covered in full to OOP maximum. Limit $1,400/unit. Maximum 2 hearing aids/36 mos. Combined INN/OON. Maintenance &amp; dispensing fees are not covered.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Limit $1,400/unit. Maximum 2 hearing aids/36 mos. Combined INN/OON. Maintenance &amp; dispensing fees are not covered.</td>
</tr>
<tr>
<td>Hearing Exam—Routine, Annual</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Deductible, then covered in full. Resource Coordination prior authorization required.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Resource Coordination prior authorization required.</td>
</tr>
<tr>
<td>Hospice Care—Facility</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required from Resource Coordination for Inpatient Services. Deductible, then $100 Copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum. IP Prior authorization required from Resource Coordination. $400 penalty without.</td>
</tr>
<tr>
<td>1. IP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. OP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Hospital</td>
<td>Deductible, then covered in full. Prior authorization required from Resource Coordination for Inpatient Services. Deductible, then $300 Inpatient Copayment. Deductible, then $100 Copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum. IP Prior authorization required from Resource Coordination. $400 penalty without.</td>
</tr>
<tr>
<td>1. Physician IP/OP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.*
## Point-of-Service Plan—2018 (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services—Diagnosis only</td>
<td>Treatment including artificial insemination and In-Vitro not covered. Medical treatment of underlying causes of infertility are covered. Based on services performed to diagnose infertility.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Treatment including artificial insemination and In-Vitro not covered. Medical treatment of underlying causes of infertility are covered.</td>
</tr>
<tr>
<td>Lab Services</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment. Copayment and Deductible waived at Designated Lab.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Mammograms/Pap Smears—Routine &amp; Non-Routine</td>
<td>No copayment. No deductible. No coinsurance. (Routine). Deductible, then covered in full (Non-Routine).</td>
<td>Deductible then 30% coinsurance to OOP maximum. (Routine/Non-Routine).</td>
</tr>
<tr>
<td>Maternity 1. Prenatal/Postnatal CDPHN</td>
<td>Deductible, then $20 copayment. Initial visit only. Follow Surgery benefits. Deductible, then $300 Inpatient Copayment. Reimbursed at 50% up to $30 (one class per pregnancy).</td>
<td>Deductible then 30% coinsurance to OOP maximum. Follow Surgery benefits. Deductible then 30% coinsurance to OOP maximum. Reimbursed at 50% up to $30 (one class per pregnancy).</td>
</tr>
<tr>
<td>Mental Health 1. IP (Prior authorization required Inpatient)</td>
<td>Deductible, then $300 Inpatient Copayment. Unlimited days. Deductible, then $20 copayment. Unlimited visits.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Unlimited days. Deductible then 30% coinsurance to OOP maximum. Unlimited visits.</td>
</tr>
<tr>
<td>Newborn Care—In Hospital</td>
<td>No copayment. No deductible. No coinsurance.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Occupational Therapy, Physical Therapy, Speech Therapy</td>
<td>Deductible, then $35 copayment. Limit 100 visits/year. Combined PT/ST/OT, INN/OON. Prior authorization required after 1st speech therapy visit.</td>
<td>Deductible then 30% coinsurance. Limit 100 visits/year. Combined PT/ST/OT, INN/OON. Prior authorization required after 1st speech therapy visit.</td>
</tr>
<tr>
<td>Organ Transplant</td>
<td>See Inpatient Hospital.</td>
<td>See Inpatient Hospital.</td>
</tr>
<tr>
<td>Physical—Routine (&gt; age 19) Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
<td>No deductible. No copayment.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Physician Office Visits PCP/OB/GYN</td>
<td>Deductible, then $20 copayment. You may use live video doctor visits at <a href="http://www.doctorondemand.com">www.doctorondemand.com</a>. Live video visits apply to the deductible, then $20 copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Podiatry—Routine</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Prescriptions—34-day supply at retail; up to a 90-day supply with mail order.</td>
<td>RETAIL: One Copayment for up to a 34-day supply. (No deductible.) Active Employees: $10 Tier 1/$35 Tier 2/ $55 Tier 3 drugs. Retirees: $10 Tier 1/$35 Tier 2/$55 Tier 3 drugs. MAIL ORDER: Two Copayments for up to a 90-day supply. No Deductible. Active Employees: $20 Tier 1/$70 Tier 2/ $110 Tier 3 drugs. Retirees: $20 Tier 1/$70 Tier 2/$110 Tier 3 drugs.</td>
<td>RETAIL: Plan pays 30% of charges to OOP Max. (No deductible). 90-day supply not covered. Active/Retirees: 30% Tier 1/30% Tier 2/ 30% Tier 3 drugs.</td>
</tr>
<tr>
<td>Private Duty Nursing 1. Home 2. Other Locations</td>
<td>Deductible, then 10% coinsurance. Deductible, then covered in full.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Deductible then 30% coinsurance to OOP maximum. Prior authorization required from Resource Coordination OON.</td>
</tr>
<tr>
<td>Prostate Cancer Diagnostic Testing</td>
<td>No deductible. No copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary Rehab</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment. Prior authorization required after 24 visits.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Prior authorization required after 24 visits.</td>
</tr>
<tr>
<td>Radiology</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment. Prior authorization required after 24 visits.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Rehabilitation—Medical</td>
<td>Deductible, then $300 Inpatient Copayment. Limit 60 days/year. Combined INN/OON. Prior authorization required from Resource Coordination for Inpatient Services.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Limit 60 days/yr. Combined INN/OON. Prior authorization required from Resource Coordination. $400 penalty without.</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Deductible, then $35 copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required for Inpatient Services or OON benefit applies.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Prior authorization required from Resource Coordination. $400 penalty without. Unlimited days.</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>Deductible, then $35 copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Follow Surgery benefits.</td>
<td>Follow Surgery benefits.</td>
</tr>
<tr>
<td>Substance Abuse 1. IP—Rehab</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required from Resource Coordination for Inpatient Services.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Unlimited days. Prior authorization required from Resource Coordination for Inpatient Services. $400 penalty without. Deductible then 30% coinsurance. Unlimited OP visits.</td>
</tr>
<tr>
<td>Detox (Prior authorization</td>
<td>$20 Copayment/visit. Unlimited OP visits.</td>
<td></td>
</tr>
<tr>
<td>required inpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery 1. Professional Services</td>
<td>Deductible, then covered in full. Prior authorization required from Resource Coordination for Inpatient Services.</td>
<td>Deductible then 30% coinsurance to OOP maximum. Prior authorization required from Resource Coordination for Inpatient Services. $400 penalty without. Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>2. IP Facility</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required for Inpatient Services.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>3. OP Facility</td>
<td>Deductible, then $100 OP Surgery Copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>4. Surgery Office</td>
<td>Deductible, then $20 PCP/$35 Specialist copayment.</td>
<td>Deductible then 30% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>TMJ</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Urgent Care Visits</td>
<td>Deductible, then $25 Copayment.</td>
<td>30% of Reasonable &amp; Customary charges, subject to deductible.</td>
</tr>
<tr>
<td>COVERED—YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • RPI’s intent is that students at school out of the area and/or member’s traveling for business or vacation need not receive authorization from The Plan in order to receive In-Network coverage for urgent care services provided out of the area. The member does not have to contact CDPHN before or after the services are rendered. 
• Services rendered within the Service Area must be at a CDPHN urgent care center for In-Network coverage. Non-participating urgent care services are covered at the OON benefit in the service area. | |
| Well-Child Care                | Covered in full. (Deductible waived.) For 1 mo., 2 mos, 4 mos., 6 mos., 9 mos., 12 mos., 15 mos., 18 mos., 24 mos., and 36 mos. Includes immunizations and lab tests as appropriate. Annual well visit age 2–19, $15 copayment applies. All other well visits $20 copayment. | Not covered. |

*Coinsurance is based on Reasonable and Customary Charges.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion—Elective</td>
<td>Follows Surgery benefit.</td>
</tr>
<tr>
<td>Accidental Dental</td>
<td>Deductible then 20% coinsurance to OOP maximum. Coverage for accidental</td>
</tr>
<tr>
<td></td>
<td>injury to sound teeth rendered within 12 mos. of accident.</td>
</tr>
<tr>
<td>Allergy Immunotherapy</td>
<td>Deductible then 20% coinsurance to OOP maximum. Allergy vials: No</td>
</tr>
<tr>
<td></td>
<td>copayment. No deductible. No coinsurance.</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered in full. No deductible. Prior authorization required to exceed</td>
</tr>
<tr>
<td></td>
<td>medical policy limits.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Covered in full. No deductible. Air ambulance not covered.</td>
</tr>
<tr>
<td>Anesthesia—IP/OP/Office</td>
<td>Covered in full. No deductible.</td>
</tr>
<tr>
<td>Blood and Blood Products IP/OP</td>
<td>Deductible, then covered in full/IP. Covered in full/OP.</td>
</tr>
<tr>
<td>Cardiac Rehab, OP/Office</td>
<td>Deductible then 20% coinsurance to OOP maximum. No visit maximum. Prior</td>
</tr>
<tr>
<td></td>
<td>authorization required after 36 visits.</td>
</tr>
<tr>
<td>Chemotherapy, Inhalation, &amp; Radiation Therapy—Facility &amp;</td>
<td>Deductible, then covered in full.</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
</tr>
<tr>
<td>Colorectal Screenings Covered</td>
<td>Routine: No deductible. No copayment. No coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Non-routine: Deductible, than $20 copayment.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Deductible then 20% coinsurance to OOP maximum. Limit 20 visits/calendar</td>
</tr>
<tr>
<td></td>
<td>year. Lab services not covered. Radiology takes separate copay.</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered in full. No deductible.</td>
</tr>
<tr>
<td>Dental-Routine</td>
<td>Delta Dental 1-800-932-0783</td>
</tr>
<tr>
<td>Diabetic Services—1. Diabetic DME</td>
<td>Covered under DME benefit. Prior authorization required for all rentals</td>
</tr>
<tr>
<td></td>
<td>and for purchases over $500.00.</td>
</tr>
<tr>
<td>2. Diabetic Drugs and Supplies</td>
<td>Covered under Prescription benefit.</td>
</tr>
<tr>
<td>3. Self-Management Education</td>
<td>Deductible then 20% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>4. Diabetic Routine Eye Exam</td>
<td>Deductible then 20% coinsurance to OOP maximum (1x every 12 months).</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Deductible then $35 copayment. Routine services covered in full. No</td>
</tr>
<tr>
<td></td>
<td>deductible.</td>
</tr>
<tr>
<td>Dialysis &amp; Hemodialysis—Facility &amp; Physician</td>
<td>Deductible then 20% coinsurance to OOP maximum. Prior authorization</td>
</tr>
<tr>
<td></td>
<td>required from Resource Coordination for Home Dialysis. Hospital based,</td>
</tr>
<tr>
<td></td>
<td>freestanding facility, home.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)—Prosthetics/Orthotics /</td>
<td>No copayment. No deductible. No coinsurance. Foot orthotics covered if</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>medically necessary and prior authorized by Resource Coordination.</td>
</tr>
<tr>
<td></td>
<td>Routine foot orthotics not covered. Prior authorization required for</td>
</tr>
<tr>
<td></td>
<td>all rentals and for purchases over $500.00.</td>
</tr>
<tr>
<td>Emergency Room (Facility Charges) COVERED—YES</td>
<td>$100 copayment, then covered in full for visit to ER. (No Deductible).</td>
</tr>
<tr>
<td></td>
<td>Copayment waived if admitted.</td>
</tr>
<tr>
<td>Emergency Room (Physician Charges) COVERED—YES</td>
<td>Covered in full, No Deductible—if emergency. Deductible then 20%</td>
</tr>
<tr>
<td></td>
<td>coverage to OOP Maximum, if non-emergency or not rendered within 48</td>
</tr>
<tr>
<td></td>
<td>hours.</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Deductible then 20% coinsurance to OOP maximum. Limit 1 exam/calendar</td>
</tr>
<tr>
<td>1. Routine</td>
<td></td>
</tr>
<tr>
<td>2. Medical</td>
<td></td>
</tr>
<tr>
<td>May self-refer to participating optometrist or ophthalmologist.</td>
<td></td>
</tr>
<tr>
<td>Deductible then 20% coinsurance to OOP maximum.</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>Deductible then 20% coinsurance. Contraceptive counseling covered in full.</td>
</tr>
<tr>
<td>Frames/Lenses/Contacts</td>
<td>100% of charges up to the maximum allowance. Deductible waived.</td>
</tr>
<tr>
<td>2. Medical</td>
<td></td>
</tr>
<tr>
<td>Deductible then 20% coinsurance to OOP maximum.</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Deductible then 20% coinsurance. Limit $1400/unit. Maximum 2 hearing</td>
</tr>
<tr>
<td>aids/36 rolling months. Maintenance and dispensing fees are not</td>
<td></td>
</tr>
<tr>
<td>covered. Replacement for loss/broken after 36 months from purchase,</td>
<td></td>
</tr>
<tr>
<td>is covered.</td>
<td></td>
</tr>
<tr>
<td>Hearing Exams—Routine</td>
<td>Deductible then 20% coinsurance to OOP maximum. One exam per calendar</td>
</tr>
<tr>
<td>year.</td>
<td></td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care (HHC)</td>
<td>No copayment. No deductible. No coinsurance. 40 visit limit/calendar year. Includes maternity HHC visit.</td>
</tr>
<tr>
<td>Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>1. IP Deductible, then $300 Inpatient Copayment. IP prior authorization required from Resource Coordination. $100 penalty without. Covered in full. No deductible. Includes 5 visits for bereavement counseling.</td>
</tr>
<tr>
<td></td>
<td>2. OP Covered in full. No deductible.</td>
</tr>
<tr>
<td>IP Hospital</td>
<td>1. Professional Covered in full.</td>
</tr>
<tr>
<td></td>
<td>2. Facility Deductible then 20% coinsurance to OOP maximum. Unlimited IP days. Deductible then 20% coinsurance to deductible to OOP maximum. Unlimited OP visits.</td>
</tr>
<tr>
<td>Immunizations—Adult &amp; Travel</td>
<td>Covered in full. No deductible. Travel immunizations not covered.</td>
</tr>
<tr>
<td>Infertility Services—Diagnosis only</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Lab Services Office/Outpatient</td>
<td>Deductible, then $35 copayment. Routine services are covered in full. No deductible.</td>
</tr>
<tr>
<td>Mammograms/Pap Smears Office/Outpatient</td>
<td>No copayment. No deductible. No coinsurance. Routine and Medical.</td>
</tr>
<tr>
<td>Maternity</td>
<td>1. Prenatal/Postnatal Deductible then 20% coinsurance to OOP maximum. Follow Surgery Professional.</td>
</tr>
<tr>
<td></td>
<td>2. Delivery Deductible then 20% coinsurance to OOP maximum. Limit 100 visits/calendar year. Combined OT/PT/ST. Prior authorization required after first visit of speech therapy.</td>
</tr>
<tr>
<td></td>
<td>3. IP Facility Deductible then 20% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td></td>
<td>4. Childbirth Class Deductible then $300 Inpatient Copayment. Prior authorization not required. Reimbursed at 50%, up to $30 (one childbirth class per pregnancy).</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1. IP Deductible then $300 Inpatient Copayment. Unlimited IP days.</td>
</tr>
<tr>
<td>(Prior authorization required inpatient; $100 penalty without)</td>
<td>Deductible then 20% coinsurance to deductible to OOP maximum.</td>
</tr>
<tr>
<td>Newborn Care—In Hospital</td>
<td>Covered in full. No deductible.</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Deductible then 20% coinsurance to OOP maximum. Medical counseling services.</td>
</tr>
<tr>
<td>Occupational Therapy, Physical Therapy,</td>
<td>Deductible then 20% coinsurance to OOP maximum. Limit 100 visits/calendar year. Combined OT/PT/ST. Prior authorization required after first visit of speech therapy.</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
</tr>
<tr>
<td>Organ Transplant</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required from Resource Coordination. $100 penalty without.</td>
</tr>
<tr>
<td>Physical—Routine (&gt; age 19)</td>
<td>Covered in full. No deductible. One per calendar year. Routine labs covered in full. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>Deductible then 20% coinsurance to OOP maximum. You may use live video doctor visits at <a href="http://www.doctorondemand.com">www.doctorondemand.com</a>. Live video visits apply to the deductible, then $20 copayment.</td>
</tr>
<tr>
<td>Podiatry—Routine</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>RETAIL: (Actives and Retirees) $10 Tier 1/$35 Tier 2/$55 Tier 3 drugs (No deductible).</td>
</tr>
<tr>
<td>Includes 90-day supply at CVS. Two copays apply.</td>
<td>MAIL ORDER: Two Copayments for up to a 90-day supply. No Deductible.</td>
</tr>
<tr>
<td></td>
<td>Retirees/Active Employees: $20 Tier 1/$70 Tier 2/$110 Tier 3 drugs.</td>
</tr>
<tr>
<td></td>
<td>2. Other Location</td>
</tr>
<tr>
<td>Prostate Cancer Diagnostic Testing</td>
<td>Covered in full. No deductible.</td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td>Deductible, then 20% coinsurance. One rehab program per lifetime. 24 visits in last 56 rolling days. Prior authorization required after visit 24.</td>
</tr>
<tr>
<td>Radiology</td>
<td>Deductible, then $35 copayment. Routine services covered in full. No deductible.</td>
</tr>
<tr>
<td>Rehabilitation (Inpatient)—Medical</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required from Resource Coordination. $100 penalty without. No day limit.</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Deductible then 20% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Deductible, then $300 Inpatient Copayment. Prior authorization required from Resource Coordination. $100 penalty without. Unlimited days.</td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.
Traditional Plan—2018 (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Office Visit</td>
<td>Deductible then 20% coinsurance to OOP maximum.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Follows Surgery benefits.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Deductible, then $300 Inpatient Copayment. Unlimited days.</td>
</tr>
<tr>
<td>(Prior authorization required</td>
<td>Deductible then 20% coinsurance to OOP maximum. Unlimited visits (visits may be used for family counseling).</td>
</tr>
<tr>
<td>1. IP—Detox and Rehab</td>
<td>Covered in full. No deductible.</td>
</tr>
<tr>
<td>2. OP inpatient. $100 penalty</td>
<td>Deductible, then $300 copayment. Prior authorization required from Resource Coordination. $100 penalty without.</td>
</tr>
<tr>
<td>Specialty Surgery</td>
<td>Deductible, then $35 copayment.</td>
</tr>
<tr>
<td>1. IP/OP Professional</td>
<td>Deductible, then $100 surgery OP copayment.</td>
</tr>
<tr>
<td>2. Facility IP</td>
<td>Not covered, if dental in nature.</td>
</tr>
<tr>
<td>3. Office</td>
<td></td>
</tr>
<tr>
<td>4. Facility OP</td>
<td></td>
</tr>
<tr>
<td>TMJ</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Visits</td>
<td>Deductible, then $25 copayment. Participating and non-participating urgent care centers covered in full.</td>
</tr>
<tr>
<td>COVERED—YES</td>
<td>Related routine immunizations, physical exam, and lab tests covered in full. No deductible. Visits at 1, 2, 4, 6, 9, 12, 15, 18, 24 and 36 months; one annual visit ages 3–19.</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td></td>
</tr>
<tr>
<td>Frequency Guidelines Apply</td>
<td></td>
</tr>
</tbody>
</table>

*Coinsurance is based on Reasonable and Customary Charges.

SECTION EIGHT—Emergency Care

When you or an enrolled family member require Emergency care, please seek medical services immediately—whether you are within or outside the service area.

A medical Emergency is defined as a medical or behavioral condition, the onset of which is sudden and which manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

All Emergency care is subject to review for medical necessity.

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

Additional Emergency care considerations.

The Plan covers Emergency outpatient care at the Emergency room of a Short-term, Acute-Care General Hospital or inpatient care in a Short-term, Acute-Care General Hospital, if the CDPHN Resource Coordination Department determines that your condition qualified for Emergency care.

- Length of Stay in a Hospital. The Plan provides care in the hospital only for as long as your Primary Care Physician determines that the hospitalization was medically necessary or that your medical condition prevented your transfer to another hospital designated by CDPHN.
- Ambulance Service. If in the judgment of your Primary Care Physician you required Emergency transportation by ambulance within the CDPHN service area, the Plan will cover 100% of the Allowed Charge for the ambulance service.
- Dental Services. The Plan will provide Emergency care immediately following trauma to sound, natural teeth consisting of trauma care, reduction of swelling, and pain relief, when authorized by your Primary Care Physician. (Restorative, periodontal, orthodontic, endodontics, and prosthodontic service or any other dental service as a result of the trauma is not covered.) Services otherwise covered under this contract will be covered for accidental injury (non-Emergency) to sound natural teeth within 12 months of the accident.
- Exclusions. Emergency benefits cover sudden onset of life-threatening illness or injury in the CDPHN service area or out of the service area. However, the Plan will not pay for Emergency care outside of the CDPHN service area in the following situations: care you could have foreseen before leaving the CDPHN service area; follow-up services (to Emergency care) that can be delayed until you return to the CDPHN service area without damage to your health.
Payments for Emergency care within the service area or outside the service area.

Point-of-Service Plan.

You are entitled to medically appropriate Emergency care at an Emergency room of a hospital, regardless of geographic location. Emergency facility services are subject to Emergency Room Copayment of $100 (waived if admitted), on the Point of Service Plan. Emergency professional services are covered in full (No copayment. No coinsurance. No deductible.) if the services are for emergency care and the care was rendered within 48 hours of the injury/illness. Professional charges at an ER are reduced to 70% coverage, after Deductible, if the services are not deemed emergent or are not provided within 48 hours of the illness/injury (indicating that it was not an Emergency). Services that are not medically necessary are not covered.

Traditional Plan.

You are entitled to medically appropriate Emergency care at an Emergency room of a hospital, regardless of geographic location. Emergency facility services are subject to Emergency Room Copayment of $100 (waived if admitted), on the Traditional Plan. Emergency professional services are covered in full (No copayment. No coinsurance. No deductible.) if the services are for emergency care and the care was rendered within 48 hours of the injury/illness. Professional charges at an ER are reduced to 80% coverage, after Deductible, if the services are not deemed emergent or are not provided within 48 hours of the illness/injury (indicating that it was not an Emergency). Services that are not medically necessary are not covered.

SECTION NINE—Home Health Care

Conditions for Home Care.

Under the Point-of-Service Plan, In-Network benefits will be provided for home health care visits authorized by your CDPHN Primary Care Physician with approval of the CDPHN Resource Coordination Department, when the following conditions are met:

A. You are home bound because of medical reasons.
B. The home care service is medically necessary as determined by your Plan Primary Care Physician.
C. There is a defined medical goal that you are expected to obtain as a result of the provision of home care services.

If you are under the care of a non-Network physician, or you are enrolled in the Traditional Plan, and a non-Network Provider has approved a written plan for your home care, the CDPHN Resource Coordination Department also must pre-authorize the care. If approved by CDPHN Resource Coordination, Out-of-Network benefits or Traditional Plan benefits apply, as appropriate.

Personnel Providing Home Care.

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

Home Care Services Provided.

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

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

Number of Home Care Visits.

The Point-of-Service Plan will provide benefits for home care visits on any day your Plan PCP determines that (i) home care was medically necessary for the care or treatment of your condition, Illness, or Injury, and (ii) if you did not receive home care you would have to be hospitalized in a Short-Term, Acute-Care General Hospital. Four hours of home health aide care shall be considered as one home care visit.

The Traditional Plan provides benefits with a maximum of 40 visits per Calendar Year.

Payments for Home Care.

Point-of-Service Plan.

The Plan will pay In-Network benefits of 100% of the Allowed Charge after Deductible has been paid. The Plan will pay Out-of-Network benefits of 70% of the Reasonable and Customary Charge, after Deductible. Pre-authorization of services is required. No visit maximum on the POS Plan

Traditional Plan.

The Plan will pay 100% of the Reasonable and Customary charges, Deductible waived, up to a maximum of 40 visits per Calendar Year. Pre-authorization of services is required.
SECTION TEN—Skilled-Nursing Facility Care

Under the Point-of-Service Plan, In-Network benefits will be provided for care in a skilled-nursing facility when the admission to the skilled-nursing facility is authorized by your Plan PCP. If you are under the care of a non-Network physician, or you are enrolled in the Traditional Plan, your admission to a skilled-nursing facility must be prior authorized by the CDPHN Resource Coordination Department, or a penalty will apply.

Type of Skilled-Nursing Facility.

The Plan will provide benefits only in a skilled-nursing facility that meets the following requirements:
- It is accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Health Care Organizations and,
- It is certified as a skilled-nursing facility under Medicare.

Number of Days of Care.

Benefits in a skilled-nursing facility will be provided on any day the CDPHN Resource Coordination Department determines that confinement in a skilled-nursing facility is medically necessary for the care or treatment of your Illness, disease, or Injury. Benefits will not be provided after the date the CDPHN Resource Coordination Department determines that confinement no longer is medically necessary.

Payments for Skilled-Nursing Care.

Point-of-Service Plan.
- Deductible, then $300 Inpatient Copayment.
- Out-of-Network, you pay 30% of the Reasonable and Customary Charge, after Deductible. You are responsible for a $400 penalty if Precertification is not obtained from the CDPHN Resource Coordination Department.

Traditional Plan.
- Deductible, then $300 Inpatient Copayment. You are responsible for a $100 penalty if Precertification is not obtained from the CDPHN Resource Coordination Department.

SECTION ELEVEN—Hospice Care

Hospice care is care provided to terminally ill patients at home or in home-like facilities by a hospice organization licensed by the state in which it is located. The services provided by hospice must be medically necessary and appropriate for the care of the patient. Care may consist of inpatient or outpatient services. Inpatient care rendered Out-of-Network on the Point-of-Service plan or covered under the Traditional Plan must be prior authorized by CDPHN Resource Coordination or a penalty applies. All services must be billed by the hospice organization.

Eligibility for Benefits.

To obtain benefits for hospice care under the Plan, the covered individual must meet the following conditions:
- He or she must experience an illness for which the attending physician's prognosis for life expectancy is estimated to be six months or less.
- Palliative care (pain control and symptom relief) rather than curative care is considered most appropriate.
- The covered individual's admission to the hospice organization must be authorized by his or her Plan PCP.
- Inpatient hospice services require CDPHN resource coordination prior authorization, or penalty may apply.

Hospice Care Benefits.

The Plan will pay for the following services when provided by the hospice organization:
- Bed patient care either in a designated hospice unit or in a regular hospital bed;
- Day care services provided by the hospice organization;
- Home care and outpatient services that are provided by the hospice organization and for which the hospice organization charges you;
- Bereavement counseling for the patient and the immediate family by a licensed social worker or licensed pastoral counselor.

Payment for Hospice Care.

Point-of-Service Plan.
- Hospice Outpatient:
  - In Network—Deductible, then covered in full.
  - Out-of-Network—30% Reasonable and Customary charges, after Deductible.
- Hospice Inpatient:
  - Deductible, then $300 Inpatient Copayment.
  - Out-of-Network—30% of Reasonable and Customary charges, after Deductible. Prior Authorization from CDPHN Resource Coordination is required, or $400 Penalty applies.
Traditional Plan.
Hospice Outpatient:
• Covered in full. Deductible waived.
Hospice Inpatient:
• Deductible, then $300 Inpatient Copayment, then Reasonable and Customary charges. Deductible waived. Prior authorization from CDPHN Resource Coordination is required, or $100 Penalty applies.

SECTION TWELVE—Private Duty Nursing

Under the Point-of-Service Plan, In-Network benefits will be provided for private duty nursing care in your home rendered on any day your Plan Primary Care Physician determines, in conjunction with the CDPHN Resource Coordination Department, that such care is medically necessary for the treatment of your Illness, disease, or Injury. If you are under the care of a non-Network physician, or you are enrolled in the Traditional Plan, you should call the CDPHN Resource Coordination Department for a determination that such care is medically necessary for the care or treatment of your Illness, disease, or Injury. If you do not call, the determination as to whether your care was medically necessary will be made at the time you submit your claim. If it was determined that the care was not medically necessary you will not be entitled to any benefits.

Personnel Providing Private Duty Nursing.

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

Payments for Private Duty Nursing.

Point-of-Service Plan.
• In-Network—Deductible then covered in full, for services rendered outside the home; Deductible then 10% coinsurance for services in the home.
• Out-of-Network—30% of the Reasonable and Customary Charge, after Deductible.
• Prior authorization required from Resource Coordination for Out-of-Network services.

Traditional Plan.
• Covered in full for services rendered outside the home (deductible waived); 20% of the Allowed Charge, after Deductible, for services in the home. CDPHN resource coordination prior authorization is required.

SECTION THIRTEEN—Prescription Drugs

Prescription Services—Coverage and Exclusions

1. Prescription Drugs: An FDA-approved Prescription Drug with an FDA approved or labeled use that can only be legally dispensed when they are ordered by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law. This includes, Medically Necessary enteral formulas which have been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which, if left untreated, cause chronic disability, mental retardation or death, if prescribed by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law. Prescription contraceptive drugs and devices are covered—See 2.r. below.

The prescription benefit administered by CDPHN consists of three categories of Prescription Drugs.

Tier 1 Drug: A Prescription Drug that takes a $10 Tier 1 Copayment.
Tier 2 Drug: A Prescription Drug that takes a $35 Tier 2 Copayment.
Tier 3 Drug: A Covered Prescription Drug that is not on Tier 1 or Tier 2 takes a $55 Copayment.

2. Coverage for Prescription Drugs is subject to the following conditions:
   a. The prescription for the drug must be filled at a pharmacy within CDPHN’s designated pharmacy benefit manager’s network.
   b. Only Medically Necessary doses of Prescription Drugs are Covered.
   c. The maximum supply shall be limited to a 34-day supply, the amount prescribed, or the commonly accepted unit of use, whichever is less. See paragraph “m” below for exceptions to the 34-day supply limitation.
   d. The pharmacy must have a valid prescription for the drug written by a duly licensed health care provider at the time the Plan participant receives the initial supply of a Covered Prescription Drug.
   e. The Plan participant must present his/her ID card and pay the dispensing pharmacy (within CDPHN’s designated pharmacy benefit manager's network) a $10 Tier 1 Copayment; a $35 Tier 2 Copayment; or a $55 Tier 3 Copayment (for a covered Prescription Drug that is neither Tier 1 nor Tier 2).
f. Unless otherwise indicated by the prescribing provider, all Prescription Drugs will be filled with Tier 1 Prescription Drugs. For the purposes of this Coverage, Tier 1 Prescription Drugs are those drugs classified as Tier 1 by CDPHN’s designated pharmacy benefits manager or are not listed on CDPHN’s formulary. Prescription Drugs which are classified as Tier 2 or Tier 3 by CDPHN’s pharmacy benefits manager are not Covered even when they are listed on CDPHN’s formulary and/or when no Tier 1 Prescription Drug is available. See Section “k” below for information on CDPHN’s formulary.

g. Refills of Prescription Drugs shall be dispensed only as ordered by a duly licensed health care provider subject to the maximum supply limitations.

h. In the event that no pharmacy within CDPHN’s designated pharmacy benefit manager’s network is able to provide the ordered Prescription Drug within a reasonable time, the Plan participant may go to any other pharmacy in the Service Area that can fill the prescription. Upon receipt from the Plan participant of a completed Claim Form or documentation deemed acceptable by CDPHN, the Plan will reimburse the Plan participant the for such Prescription Drug, set out in “e” above.

i. Injectable fertility drugs, injectable or implantable contraceptive drugs prescribed for non-contraceptive purposes, and intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered are Covered and must be prior approved by CDPHN’s Medical Director or his/her designee. These items will be subject to the Copayment set out in “e” above. This includes intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered, but are being administered by the practitioner in his/her office for reasons other than medical necessity.

j. Compounded medications are considered Tier 3 Prescription Drugs and must contain at least one FDA approved ingredient with an FDA approved or labeled use.

k. Coverage is subject to the CDPHN Prescription Drug Formulary that is in effect on the date the prescription is filled. The following types of Prescription Drugs may require prior approval:
   - Specialty pharmacy agents (see l. below)
   - Injectables
   - Recombinant DNA products
   - Immune-modulating agents
   - Monoclonal antibodies
   - Enteral formulas/modified solid food products
   - Weight loss agents
   - Cosmetic agents used for non-cosmetic medical diagnoses
   - Compounded presciptions
   - COX-2 inhibitors
   - All new to market Prescription Drugs or molecular entities until reviewed by CDPHN’s Pharmacy and Therapeutics (P&T) committee.
   - Drugs that are recommended by P&T committee to be reviewed due to clinical effectiveness and/or safety profile or that have requirements based on the evaluation of other medical criteria.
   - Prescription Drugs used off-label (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) other than those where the use is supported by certain reference-book citations. (These reference books, as amended, are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, then the drug will not be Covered.

It is the Plan participant’s responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in the Plan participant being responsible for the total cost of the drug. Plan participants may also contact the Member Services Department at (518) 641-3100 or 1-877-724-2579 or may consult the CDPHP website at www.cdphp.com to determine whether a Prescription Drug is listed on CDPHN’s Specialty drug list.

l. Specialty pharmacy agents must be obtained at CDPHN’s participating specialty vendor(s). Up to a 34-day supply is available. Specialty Drugs may be administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical, or inhalation. CDPHN designates drugs as specialty through evaluation of the following characteristics: frequency of dosage adjustments, frequency of severity of adverse effects and side-effects, requirements for storage, handling and/or administration, therapeutic range, frequency of required laboratory or diagnostic testing for monitoring safety or effectiveness, increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home health care therapy, requirements for significant on-going one-to-one patient support and education to maintain patient compliance and to ensure the proper storage/handling/administration of the drug, severity of compliance risk, need for work-life adjustments by patients or caregivers to adhere or successfully implement the therapy and limited distribution of the drug. Prescription Drugs listed on CDPHN’s specialty drug list which require prior authorization as part of a clinical management program must be obtained at CDPHN’s participating specialty pharmacy vendor(s), for up to a 34-day supply, upon prior approval from CDPHN. Specialty pharmacy agents used to treat the following diseases: asthma, growth hormone, hepatitis C, HIV, infertility, MS, psoriasis, pulmonary hypertension, osteo/rheumatoid arthritis, oral oncology drugs, implantable drugs used for endometriosis, prostate cancer, breast cancer, cystic fibrosis, Gaucher disease, congenital alpha-1 inhibitor deficiency, Fabry disease, Mucopolysaccharidosis-1, anemia, neutropenia, thrombocytopenia, and complications of chronic granulomatous disease or osteopenosis must be obtained at the specialty vendor(s). Plan participants may also contact the CDPHN Member Services Department at (518) 641-3100 or 1-877-724-2579 or may consult the CDPHN website at www.cdphp.com to determine whether a Prescription Drug is listed on CDPHN’s specialty drug list meets the requirement for Prior Authorization.
m. CDPHN-approved maintenance drugs for chronic conditions are available by mail order, except specialty pharmacy agents, subject to the following Copayments: up to a 90-day supply will be dispensed subject to a two-month Copayment. A 34-day supply or less will be subject to a one-month Copayment. Contact the CDPHN Member Services Department for instructions on using the mail order program. A 90-day supply is also available from CVS Pharmacies. A two-month Copayment applies.

n. Prescription Drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or that contain modified protein which are Medically Necessary.

o. Certain Covered Prescription Drugs that due to quality and/or clinical consideration or use for lifestyle may be limited in coverage based on medical necessity. All requests for these Prescription Drugs will be subject to CDPHN’s utilization review process including all avenues of appeals.

p. Prescription Drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility are Covered.

q. Prescription Drugs and devices that are approved by the federal Food and Drug Administration for purposes of bone mineral density measurements and testing are Covered.

r. Contraceptive drugs and/or devices that require a prescription and are prescribed for contraceptive or non-contraceptive purposes are Covered.

s. Over-the-counter drugs that are included on CDPHN’s formulary are subject to the Tier 1 Copayment.

t. Drugs used for weight loss and/or the management of obesity require prior approval by the CDPHN Medical Director or his/her designee in conjunction with approved medical management guidelines.

3. The following items are excluded from Coverage:

a. Over-the-counter drugs that are not on the formulary, or any drug not requiring a prescription.

b. A Prescription Drug will not be covered if there is an over-the-counter drug with same active ingredients.

c. Vitamins, except those requiring a prescription, even if they are ordered by a Participating Practitioner.

d. Experimental and/or investigative drugs, unless recommended by an external appeal agent. All determinations regarding requests for potentially experimental and/or investigative drugs will be subject to Section Sixteen—Exclusions, including all avenues of appeals, Section Twenty—Claims, Complaints, and appeals.

e. Devices of any type (except those devices specifically Covered in paragraph 2.q. or 2.r. above), such as, but not limited to, syringes, therapeutic devices, appliances, and hypodermic needles, even if they must be ordered by the provider.

f. Refills will not be Covered if they are needed because a Plan participant loses or misuses his/her supply of Prescription Drugs, even if such a refill is ordered by the provider.

g. Prescription refills in excess of the number specified by the provider or dispensed more than one year from the date of the provider's original order.

h. Any drug, medicine, or medication used for cosmetic purposes. All determinations regarding requests for potentially cosmetic drugs, medicine, or medication used for cosmetic purposes will be subject to Section Sixteen—Exclusions, including all avenues of appeals.

i. Drugs used in connection with a non-Covered service or a non-Covered benefit.

j. Drugs or pharmacological therapies recognized by CDPHN as being not Covered.

k. Elective nutritional supplements.

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

The Plan will provide In-Network benefits for durable medical equipment, prosthetic appliances, orthotics, and hearing aids described below when, under the Point-of-Service Plan, they are prescribed by your Plan PCP. Out-of-Network benefits apply when prescribed by your non-Network physician. The Traditional Plan benefits apply when your physician prescribes, as outlined below. CDPHN resource coordination prior authorization required for all rentals and for purchases over $500.

**Durable Medical Equipment.**

The use of the equipment must be directly related to the treatment of your condition. Durable medical equipment is equipment that is intended for repeated use and is not generally useful to a person in the absence of illness or injury. The equipment must be of a kind that generally is used only to treat a medical condition. The equipment will be rented unless the CDPHN Resource Coordination Department determines that it is less expensive to purchase. If the equipment is purchased, the Plan also will pay for repairs and necessary maintenance.

The items the Plan will pay for include, but are not limited to, oxygen and oxygen equipment, a non-motor driven wheelchair, hospital bed, braces or crutches. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.
Items the Plan will not pay for include, but are not limited to, deluxe equipment (such as a motor-driven wheelchair) when standard equipment is available and medically adequate, items not medical in nature, comfort and convenience items, disposable supplies (other than bandages and dressings), exercise and hygiene equipment, sauna bath, air conditioners, humidifiers and dehumidifiers, experimental or research equipment, and electronic communication devices.

**Diabetic DME Services.**

Diabetic equipment is covered under DME. Diabetic supplies are covered under the Pharmacy benefit.

Diabetic self-management education takes a copayment for each visit, in network, on the POS plan; and 20% of the Reasonable and Customary Charge after deductible on the Traditional Plan. There are no out-of-network benefits on the POS plan.

**Orthotics.**

The Plan provides benefits for orthotics. Foot orthotics must be medically necessary to qualify for coverage. Routine foot orthotics are excluded from coverage. Routine podiatry is also excluded from coverage.

**Prosthetic Appliances.**

The Plan will pay for prosthetic appliances the uses of which are directly related to the treatment of your condition. A prosthetic appliance aids body functioning or replaces a limb or body part after surgical or accidental loss. Items the Plan will pay for include, but are not limited to, artificial limbs or eyes, post-mastectomy prosthetics, and post-laryngectomy prosthetics.

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

**Hearing Aids.**

The Plan will pay for up to two hearing aids with a dollar maximum of $1,400 per unit (after deductible is paid), once every 36 months IN and OON combined. (If each unit is acquired at a different time, the 36-month period is tracked separately for each unit.) If you lose or break your hearing aid the Plan will not pay for a replacement until the expiration of the 36-month period.

**Payments for Durable Medical Equipment, Prosthetic Appliances and Hearing Aids.**

**Point-of-Service Plan.**

- In-Network—Deductible then covered in full. (Hearing Aid Maximum applies.)
- Out-of-Network—30% of the Reasonable and Customary Charge, after Deductible. (Hearing Aid Maximum applies.)

**Traditional Plan.**

- Covered in Full, No Deductible for durable medical equipment, orthotics, and prosthetic appliances, and for hearing aids. (Hearing Aid Maximum applies.)

**SECTION FIFTEEN—Vision Care**

The Plan will pay up to the Maximum Benefit listed below for a pair of glasses, or contact lenses, or frames only or lenses only. The Plan covers 100% of charges up to the Maximum Benefit (see Maximum Benefit in grid below). The Plan will also pay for one exam per Calendar Year unless there has been a prescription change of at least .5 diopters. Measuring for proper fit is included in the covered visit.

<table>
<thead>
<tr>
<th>Options included in allowance:</th>
<th>Maximum Benefit</th>
<th>Maximum Benefits Lenses Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Single Vision Lenses and Frames</td>
<td>$236</td>
<td>$118</td>
</tr>
<tr>
<td>B. Bifocals Lenses and Frames</td>
<td>$304</td>
<td>$186</td>
</tr>
<tr>
<td>C. Trifocals Lenses and Frames</td>
<td>$311</td>
<td>$193</td>
</tr>
<tr>
<td>D. Frames Only</td>
<td>$118</td>
<td>N/A</td>
</tr>
<tr>
<td>E. Contact Lenses</td>
<td>$236</td>
<td>N/A</td>
</tr>
<tr>
<td>F. Transitional Lenses</td>
<td>$311</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Each Maximum Benefit listed above applies to the POS In-Network, POS Out-of-Network and Traditional Plans. Only one of the options above (A–F) is covered per calendar year.
SECTION SIXTEEN—Exclusions

1. Any Accidental Injury or illness for which benefits, settlement(s), award(s) or damages are received or payable from a claim under:
   a. Workers’ Compensation;
   b. Employer’s Liability, or Occupational Disease Law; or
   c. Medicare.

2. No benefits will be paid under the Plan for any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable. Any loss or portion thereof, for which benefits are provided under the Plan which are not recovered or recoverable from mandatory no-fault insurance, because such loss exceeds the maximum benefits provided under such mandatory no-fault insurance, shall be paid without regard to the Coinsurance and/or Copayment provisions set forth in the Plan. Any loss, or portion thereof, for which benefits are provided under the Plan which is not received or recoverable from mandatory no-fault insurance because of a no-fault deductible shall be paid subject to the Coinsurance and/or Copayment provisions set forth in the Plan.

3. Health Services for the treatment of Mental Health Conditions, except for acute mental, nervous or emotional disorders which are susceptible to short-term treatment and pose a serious threat to the mental or physical well-being of the Participant; medication management and neuropsychological testing related to a medical Diagnosis.

4. Prescription drugs and biologicals are excluded under the medical portion of the Plan except the following: (Refer to the Prescription Covered Services section that follows for those drugs and biologicals that are not referenced below.)
   a. Those received during a Covered inpatient admission to a Hospital, or Skilled Nursing Facility;
   b. Those received during the course of receiving Covered Home Health Care Services;
   c. intravenous (IV) and intramuscular (IM) prescription drugs and biologicals when provided in conjunction with an approved Home Health Care nursing plan.
   d. Covered immunizations administered by a Participating Practitioner in his/her office;
   e. Covered allergy immunotherapy administered by a Participating Practitioner in his/her office;
   f. Diagnostic testing agents used during Covered diagnostic procedures;
   g. Intravenous (IV) and intramuscular (IM) prescription drugs or biologicals administered by a Participating Practitioner in his/her office. This Coverage does not apply to injectable fertility drugs, injectable or implantable contraceptive drugs or to intravenous (IV) and intramuscular (IM) prescription drugs or biologicals which are usually considered to be self-administered, but are being administered by the Participating Practitioner in his/her office or by a Home Health Care agency for reasons other than Medical Necessity. All determinations of medical necessity are subject to CDPHN’s Utilization Review process including all avenues of appeals.

5. Durable Medical Equipment, prosthetics, orthotics and supplies, except as explicitly provided in the Plan document. Duplicate equipment or devices (e.g. one for home and one for school). Repair or replacement of Durable Medical Equipment, prosthetic devices or orthotic devices due to loss, misuse or neglect. Equipment or devices which serve as comfort or convenience items. Environmental control items including, but not limited to, air conditioners, humidifiers, dehumidifiers and/or air purifiers. Repairs of equipment or devices that are subject to manufacturer warranty. Charges related to the shipping, handling and/or delivery of Covered equipment or devices. Equipment or devices prescribed solely for use during sports or for employment. Computer assisted communication devices or electronic communication devices that are not implanted into the body. Medical supplies and supplies associated with Covered devices or equipment that are included in the rental fee or purchase price of the device or equipment are covered.

6. Any dental care and treatment except for the treatment of sound natural teeth needed as a result of an Accidental Injury or treatment needed due to a congenital disease or anomaly. Dental care and treatment needed as a result of an Accidental Injury is not Covered when it is provided more than 12 months from the date of the Accidental Injury, except when prior approved by the CDPHN Medical Director or his/her designee for Participants whose future growth prohibits necessary treatment from being performed within 12 months of the Accidental Injury.

7. Coverage for temporomandibular joint disease (TMJ) is excluded when it is dental in nature.

8. Non-Medically Necessary cosmetic services, including plastic surgery, and elective treatment for aesthetic improvement of nondisabling physical defects or problems. This exclusion shall not apply to a cosmetic operation when it is Medically Necessary, or reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Covered Dependent child which results...
in a functional impairment. Reconstructive surgery shall not include surgery for scar repair/revision only, where no functional
defect is present. Requests for potentially cosmetic procedures and services will be subject to the CDPHN Utilization Review
process including all avenues of appeals. Nothing herein shall be interpreted to preclude the application of Insurance Law § 4303
regarding breast reconstruction surgery after a mastectomy.

9. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to
as “Procedures”) not proved to be safe and/or efficacious, or, because of a Participant's condition, an efficacious procedure
that will have no effect on the outcome of the Participant's illness, injury or disease are not Covered. Benefits are limited to
scientifically established Procedures that have been evaluated by recognized United States authorities or United States govern-
mental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness,
injury or disease. Procedures that are ineffective or are in the stage of being tested or researched with question(s) as to safety
and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a
particular illness, injury or disease which have received approval from the Federal Food and Drug Administration and/or the
Agency for Healthcare Research & Quality may be Covered. CDPHN reserves the right to determine Coverage on a case-by-

10. Health Services which are not Medically Necessary for the diagnosis and treatment of an Accidental Injury or illness or to
maintain the Participant's health. The Plan only covers Medically Necessary services.

11. Maintenance, dispensing fees, and fitting of hearing aids.

12. Personal conveniences while an inpatient in a Hospital or other health care facility, such as private room, television, barber or
beauty services, guest services and similar incidental services and supplies which are not Medically Necessary as part of the care
for the Participant.

13. Services performed by a Participant's immediate family including spouse, brother, sister, parent or child.

14. Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research,
travel, school or camp, or related to judicial or administrative orders or proceedings; or related to medical research.

15. Free care or care where no charge, in the absence of the Plan, would be made to the Participant.

16. Benefits provided under Medicare or other governmental programs (except Medicaid), or services for which, in the absence
of any Health Services plan or insurance plan, no charge would be made to the Participant.

17. Any injury or illness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any
country to the extent Coverage for such injury or illness is provided through any governmental plan or program.

18. Travel and transportation expenses even though prescribed by a physician, except as provided in the Plan document.

19. Inpatient Hospital services, unless prior-authorized by CDPHN Resource Coordination or Medically Necessary because of
an Emergency.

20. Hospital clinic services unless arranged in advance by a Participating Physician and prior approved by the CDPHN Medical
Director or his/her designee.

21. Long-term Physical/Speech/Occupational Therapy and/or long-term rehabilitation.

22. Benefits otherwise provided in the Plan which CDPHN is unable to provide because of any law or regulation of the federal,
state or local government, or any action taken by any agency of the federal, state or local government in reliance on said law
or regulation.

23. Non-Emergency Health Services rendered outside the Service Area where the Participant should have reasonably foreseen the
need for such services prior to leaving the Service Area, unless CDPHN approves such services in writing, in advance.

24. Any expense as a result of a Participant's failure to vacate his/her Hospital bed beyond the discharge time or date established
by the Hospital, Participating Physician and CDPHN.

25. Orthotic shoe inserts and routine foot care (routine podiatry). This includes services or care in connection with any of the
following: corns, calluses, flat feet, fallen arches, weak feet, chronic strain or symptomatic complaints of the feet.

26. Any Health Services resulting from a Participant's commission of a felony.

27. Non-Medically Necessary custodial care or rest cures and services rendered for the convenience of a Participant or provider. Care
is considered custodial when it is primarily for the purpose of helping the Participant with daily living or meeting personal needs
and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes
help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. All requests for potentially custodial
procedures and services will be subject to the CDPHN Utilization Review process including all avenues of appeals under the Plan.

28. Court-ordered treatment for Mental Health Conditions and/or Health Services, unless such treatment and/or services are
rendered by a Participating Provider and are determined to be Medically Necessary.

29. Services required by an employer.

30. Dietary supplements or replacements. Not included in the exclusion is total parenteral nutrition.

31. Intensive weight loss programs.

32. Storage of blood or blood products. This does not apply to autologous (one’s own blood) blood donations. Benefits for transfusion
services, including storage, for autologous donations of blood and blood components are available when associated with a
scheduled, Covered Surgical Procedure.
33. Infertility services and assisted reproductive services, including, but not limited to, the following: in vitro fertilization; ZIFT (Zygote Intrafallopian Transfer); GIFT (Gamete Intrafallopian Transfer); and all expenses related to surrogate pregnancy; sperm and ovum banking; all charges related to procurement or storage of donor gametes; donor fees associated with artificial insemination and all expenses related to reversal of voluntary sterilization, including vasectomy and tubal ligation, sex change procedures, cloning or medical or surgical procedures that are deemed experimental in accordance with the standards and guidelines established and adopted by the American Society for reproductive Medicine.) Also excluded are gamete or embryo donation and services to maintain a pre-viable embryo.

34. Devices or equipment used primarily for the purpose of athletic activities.

35. Benefits or services prescribed by a physician but not expressly Covered by the Plan.

36. Laboratory services are not Covered unless provided in accordance with the Plan.

37. CDPHN will not provide Coverage for non-Medically Necessary transplants of artificial or animal organs. All requests for potentially experimental or investigative procedures and services will be subject to CDPHN's Utilization Review process including all avenues of appeals under the Plan. CDPHN will not provide coverage for travel, food and lodging for transplant recipient or donor, or costs relating to searches or screenings beyond that provided for under the Plan (see Organ Transplant benefit in this document and refer to the Plan document) for donors of organs to be transplanted.

38. Treatment provided in a governmental Hospital, or other institution which is owned, operated or maintained by the Veterans Administration, the federal government, a state government, or any local government, unless the Hospital is a Participating Provider. However, CDPHN will pay for care Covered under the Plan in a governmental Hospital, if because of serious injury or sudden illness, a Participant is taken to such a Hospital for Emergency care because it is close to the place where he/she was injured or became ill. In this type of Emergency situation, CDPHN will continue to make payments only for as long as Emergency care, in the sole judgement of CDPHN, is necessary and until it is possible for the Participant to be transferred to a Participating Provider Hospital.

39. The Participant is financially liable for services received from a non-Participating Provider (except with prior written approval from CDPHN), for services received from any provider without the required authorization from CDPHN, or for any non-Covered procedure, treatment or service, or any other service-related to a non-covered service.

40. Non-Medically Necessary Transsexual surgery and all related services. All requests for potentially non-Medically Necessary procedures and services will be subject to CDPHN's Utilization Review process including all avenues of appeals under the Plan.

41. Travel Immunizations, POS Out-of-Network and Traditional Plan.

42. Acupuncture.

43. Growth hormones for short stature when not medically necessary.

44. Surgical treatment of morbid obesity.

45. Methadone maintenance.

46. The Plan will not provide Mental Health Care for conditions that include motor disorders, communication disorders, and mental retardation solely for the purposes of education.

47. The Plan will not provide Mental Health Care for the treatment of dementia.

48. The Plan will not provide benefits for the costs for Mental Health and/or Substance Abuse services resulting from a court order or an administrative order, such as by the Department of Motor Vehicles, unless such services are determined to be Medically Necessary. Such services include, but are not limited to, custodial evaluations, special medical reports not directly related to treatment, and reports prepared in connection with legal actions.

49. The Plan will not provide benefits for marriage counseling, pastoral or religious counseling, compulsive gambling, assertiveness training, music or art therapy or recreational therapy, caffeine cessation therapy, hypnosis and hypnotherapy, rolling, psychodrama, psychoanalysis, self-treatment or self-help training.

50. The Plan will not provide benefits for services required to determine appropriate educational placement for services or for other educational testing. We will also not provide benefits for special education and related services, assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations, including but not limited to therapy services, cognitive retraining and rehabilitation, services for remedial education, evaluation and treatment of learning disabilities and disorders, interpreter services and lessons in sign language.

SECTION SEVENTEEN—Coordination of Benefits and Subrogation

When You Have Other Health Benefits.

It is not unusual to find yourself covered by two group health insurance contracts, plans, or policies providing similar benefits. When that is the case and you receive an item or service that would be covered by both policies, the Plan will coordinate benefit payments with any payment made under the other policy or plan. One plan will pay its full benefit as a primary benefit. The other plan will pay secondary benefits if necessary. This prevents duplicate payments and overpayment. Each of the following is considered to be a health insurance policy or plan:

A. Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered to be a health insurance policy.
B. Any self-insured or non-insured plan, or any other plan arranged through any employer, company trustee, union company organization, or employee benefit organization.

C. Any Blue Cross, Blue Shield, or other service type group plans or group remittance subscriber contracts.

D. Any coverage under governmental programs, or any coverage required or provided by a statute. However, Medicaid and any plan whose benefits are, by law, in excess of those provided by any private insurance plan or other non-governmental plan shall not be considered a health insurance policy.

E. Medical benefits coverage in-group and individual mandatory automobile traditional “fault” type contracts.

Rules to Determine Payment.

In order to determine which policy or plan is primary, certain rules have been established. The first of the rules listed below that applies shall determine which policy or plan shall be primary:

- If the other policy or plan does not have a provision similar to this coordination of benefits, then the other policy or plan will be primary.
- If you are covered under one policy or plan as an employee or member of the group and you are covered as a dependent under the other policy or plan, the policy or plan that covers you as an employee or Participant of the group will be primary.
- Subject to the provisions in paragraphs 1 and 2 below, for children covered under both policies or plans, the policy or plan of the parent whose birthday (month and day) falls earlier in the year is primary. If both parents have the same birthday, the policy or plan that covered the parent longer is primary.

1. If the other policy or plan does not have the rule described above, but instead has a rule based on sex of a parent and, as a result, the policies, or plans, do not agree on which shall be primary, the policy or plan under which you are covered will be primary for the dependent of a male person.

2. If a dependent child’s parents are separated or divorced, benefits for the child are determined in this order:
   - First, the policy or plan of the parent with custody of the child.
   - Then, the policy or plan of the spouse of the parent with custody of the child.
   - Finally, the policy or plan of the parent not having custody of the child.

However, if the terms of a court decree state the order of responsibility and the entity obligated to pay or provide the benefits of the policy of that parent has knowledge of this decree, that parent’s policy or plan shall be primary.

If you are covered under one of the policies or plans as an active employee (neither laid-off or retired), or as the dependent of an active employee, and you are covered as a laid-off or retired employee, or you are covered by reason of continuation of coverage rights under state or federal law or as a dependent of such person, under the other policy or plan, the policy or plan covering you as an active employee will be primary. If the other policy or plan does not have this rule, however, and as a result the policies or plans do not agree on which shall be primary, this rule shall be ignored.

If none of the above applies, then the policy or plan that has covered you for the longest time will be primary.

The above rules apply whether or not you make a claim under both policies (or plans).

Payment of Benefits When The Plan is Secondary.

When the Plan is secondary, the benefits of the Plan will be reduced so that the total benefits payable under the other policy or plan and the Plan do not exceed the charges for the service, but in no event will the Plan pay more than it would have paid if it were primary. Note: When plan is secondary, prior authorization is not required for inpatient hospital service.

Coordinating payment of Benefits When Medicare is Primary.

The Plan coordinates health benefits with Medicare. The Plan pays health benefits after Medicare for retired employees and/or their dependents eligible for Medicare or disabled employees. Benefits available under Medicare are deducted from the amounts payable under the Plan, whether or not the person has enrolled for Medicare. Rensselaer retirees and their spouses age 65 and older should enroll for both Parts A and B of Medicare. Otherwise, the Plan or Medicare may not cover the expenses.

A. Medicare and Coordination of Benefits

The Plan pays benefits after Medicare has paid its benefits.

If a person also is covered under another group plan and federal rules require that other group plan to pay primary to Medicare, the Plan is secondary to both that plan and Medicare.

This is true even if the Plan is determined to be primary to that other group plan by the rules shown in Coordination of Benefits. Federal rules determine the order of payment between Medicare and the other plan.

Medicare Pays First and the Physician Accepts Assignment:

If the Provider has agreed to limit charges for services and supplies to the amount approved by Medicare, then the Provider is said to have “accepted assignment.” When a Provider accepts assignment, the Provider agrees to bill no more than Medicare’s approved amount. Any difference between the physician’s charges and Medicare’s approved amount is not the responsibility of the covered person.
When Medicare is primary and the Provider has “accepted assignment” the Plan will calculate the amount of the covered expense using the Medicare approved amount.

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

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

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

  **The Plan pays $0.** Although the Plan considers $90 to be the reasonable charge, the Plan calculates 100% of the Medicare Allowed Charge ($70) and determines $70 is the Plan benefit. In this instance the $20 copay + Medicare ($56) + $0 = $71.**

  **You pay:** $20 copay when the service is provided. You are not responsible for the difference between the physician charges and the Medicare Allowed Amount. The provider is responsible for reimbursing you $6.00.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows*</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$56</td>
<td>$0</td>
<td>$20 Copay</td>
</tr>
</tbody>
</table>

* Physician required to accept

**Example (b)—Out-of-Network payment for an office visit.**

- **Plan Benefit:** 70% of the Allowed Charge, subject to Deductible. For this example, assume the Participant has NOT satisfied Deductible.
- **Physician:** charges $100.
- **Medicare:** allows $70 and pays 80% of the allowed amount, or $56.00.

  **The Plan pays $0.** Although the Plan considers $90 to be the reasonable charge, in this example, the Participant has not yet met the annual Out-of-Network Deductible, so the Participant is responsible for the remaining $14 (towards the Deductible). The Plan is not responsible for payment in this example.

  **You pay:** $14.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows*</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$56</td>
<td>$0</td>
<td>$14 Deductible</td>
</tr>
</tbody>
</table>

* Physician required to accept

**Conversely, in the same situation, if the Deductible had previously been met:**

**Example (c)—Out-of-Network payment for an office visit.**

- **Plan Benefit:** 70% of the Allowed Charge, subject to Deductible. For this example, assume the Participant has previously satisfied Deductible.
- **Physician:** charges $100.
- **Medicare:** allows $70 and pays 80% of the allowed amount, or $56.

  **The Plan pays $0.** Although the Plan considers $90 to be the reasonable charge, the Plan calculates 70% of the Medicare Allowed Charge ($70) and determines $49 is the Plan benefit. Medicare is providing the Participant with a greater benefit than the Participant would have enjoyed from the Plan, had the Plan been primary.

  **You pay:** $14.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows*</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$56</td>
<td>$0</td>
<td>$14</td>
</tr>
</tbody>
</table>

* Physician required to accept

**Example (d)—Traditional Plan payment for an office visit.**

- **Plan Benefit:** 80% subject to Deductible and Out of Pocket Maximum. For this example, assume the Participant has previously satisfied Deductible.
- **Physician:** charges $100.
- **Medicare:** allows $70 and pays 80% of the allowed amount, or $56.00.

  **The Plan pays $0.** Although the Plan considers $90 to be the reasonable charge, the Plan calculates 80% of the Medicare Allowed Charge ($70) and determines $56 is the Plan benefit. Medicare is providing the Participant with a benefit equal to the Plan benefit, had the Plan been primary.

  **You pay:** $14.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows*</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$56</td>
<td>$0</td>
<td>$14</td>
</tr>
</tbody>
</table>

* Physician required to accept
Example (e)—Traditional Plan payment for surgery.

**Plan Benefit:** 100% subject to Deductible and Out of Pocket Maximum. For this example, assume the Participant has previously satisfied Deductible.

**Physician:** charges $100.

**Medicare:** allows $70 and pays 80% of the allowed amount, or $56.00.

**The Plan pays:** $14. Although the Plan considers $90 to be the reasonable charge, the Plan calculates 100% of the Medicare Allowed Charge ($70) and determines $70 is the Plan benefit. The Plan pays the difference between Plan benefit and Medicare benefits.

**You pay:** $0.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows*</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$56</td>
<td>$14</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Physician required to accept

**Medicare Pays First and Physician Does Not Accept Assignment:**

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

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

a) The reasonable charges, or
b) The amount that the Provider charged.

* Next, The Plan determines the amount payable without regard to Medicare benefits.
* The Plan then subtracts the amount payable under Medicare from amount payable under the Plan benefits. *The Plan pays only the difference between Medicare benefits and the Plan benefits for the same expenses.*

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

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

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

Example (g)—Out-of-Network payment for an office visit.

**Plan Benefit:** 70% of Allowed Charge, subject to Deductible.

**Physician:** charges $100. *(Note, Participant is not responsible for charges that are more than 15% above the Medicare allowed amount. Therefore physician charges are limited to $80.50.)*

**Medicare:** allows $70 and pays 80% of the allowed amount, or $56.00.

**The Plan pays:** $7. The Plan calculates 70% of the $90 Reasonable Charge and determines $63 is the Plan benefit. The difference between the Medicare benefit ($56) and the Plan benefit ($63) is $7.

**You pay:** $17.50. This is the difference between the $80.50 and the total of Medicare ($56) and the Plan ($7) benefits.

<table>
<thead>
<tr>
<th>Cost*</th>
<th>Medicare Allows*</th>
<th>UCR</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$90</td>
<td>$56</td>
<td>$7</td>
<td>$17.50</td>
</tr>
</tbody>
</table>

* Physician required to accept

Example (h)—Traditional Plan payment for an office visit.

**Plan Benefit:** 80% subject to Deductible and Out-of-Pocket Maximum.

**Physician:** charges $100. *(Note, Participant is not responsible for charges that are more than 15% above the Medicare allowed amount, therefore the physician charge is limited to $80.50.)*

**Medicare:** allows $70 and pays 80% of the allowed amount, or $56.

**The Plan pays:** $16. The Plan calculates 80% of the $90 Reasonable Charge and determines $72 is the Plan benefit. The difference between the Medicare benefit ($56) and the Plan benefit ($72) is $16.

**You pay:** $8.50.

<table>
<thead>
<tr>
<th>Cost*</th>
<th>Medicare Allows*</th>
<th>UCR</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$90</td>
<td>$56</td>
<td>$16</td>
<td>$8.50</td>
</tr>
</tbody>
</table>

* Physician required to accept
Example (i)—*Traditional Plan payment for surgery.*

**Plan Benefit:** 100% subject to Deductible and Out-of-Pocket Maximum.

**Physician:** charges $100. (Note, Participant is not responsible for charges that are more than 15% above the Medicare allowed amount; therefore payment ceiling is $80.50.)*

**Medicare:** allows $70 and pays 80% of the allowed amount, or $56.

The **Plan pays:** $34. The Plan calculates 100% of the $90 Reasonable Charge and determines $90 is the Plan benefit. The difference between the Medicare benefit and the Plan benefit is $34.

You pay: $0.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Medicare Allows</th>
<th>UCR</th>
<th>Medicare Pays</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$70</td>
<td>$90</td>
<td>$56</td>
<td>$34</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Physician required to accept

**Right to Receive and Release Necessary Information.**

CDPHN has the right to release or obtain information it believes is necessary to administer this coordination of benefits provision. CDPHN will not notify you or obtain your consent before releasing or obtaining information. CDPHN will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to CDPHN any relevant information it requests. The Plan reserves the right to deny benefit payments if you refuse to comply with CDPHN’s request for information.

**Payments to Others.**

The Plan may repay to any third party—a person, an insurance company, or other organization—the amount that party paid for your covered services that CDPHN determines should have been paid under the provisions of the Plan. These payments are the same as benefits paid to you and they satisfy the Plan’s obligation to you.

**The Plan’s Right to Recover Overpayment.** In some cases the Plan may have made payment even though you had coverage under another policy or plan. Under these circumstances, it will be necessary for you to refund to the Plan the amount by which the Plan should have reduced its payment. The Plan also has the right to recover the overpayment from the other health benefits program if you have not already received payment from that other program. You must sign any document that CDPHN regards as necessary to help it recover any overpayment.

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

**SECTION EIGHTEEN—Termination of Coverage Under The Plan**

**When Your Coverage Ends.**

Coverage under the Plan ends on the earliest of the following dates, unless “COBRA” coverage is available and elected, as stated at the end of this Paragraph:

- In the case of your death, on the last day of the month of your death.
- If your employment terminates for any reason, such as resignation or layoff, your coverage will end on the last day of the month in which your employment terminated.
- At the end of the period for which contributions have been paid, if you fail to make further contributions or you cancel your payroll deduction authorization.
- If you are covered as a spouse and you get a legal separation, divorce, or your marriage is annulled, your coverage will end on the last day of the month in which legal separation, divorce, or annulment occurs.
- If you are covered as a child, your Coverage will end on the last day of the month you reach the age of 26, unless you are a handicapped child, as defined in SECTION THREE—Who Is Covered.
- On a date, as determined by CDPHN and RPI, that you or your family member intentionally provided false information or made misrepresentations in connection with a claim for benefits; or permitted a non-Participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits under the Plan; or obtained or attempted to obtain benefits by reason of false, misleading, or fraudulent information, acts or omissions; or failed to make any Copayment, supplemental charge, or other amount due with respect to a benefit under the Plan; or behaved in a manner disruptive, unruly, abusive, or uncooperative to the extent that the Plan is unable to provide benefits to you or your family members; or threatened the life or well-being of personnel administering the Plan or of Providers of services or benefits.

—35—
When your coverage ends, you and your covered family members may continue coverage under the Plan through a federal law known as COBRA, if the event that causes coverage to end is a “qualifying event” that gives rise to COBRA rights as explained in SECTION NINETEEN—Continuation of Coverage Under Cobra and Eligibility Under a QMCSO.

**Supplementary Suspension and Continuation Rights.**

If you, the person to whom the Plan is issued, are a member of a reserve component of the armed forces of the United States, including the National Guard, and you enter active duty but Rensselaer does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to Rensselaer, within 60 days of being ordered to active duty, to continue coverage under the Plan for yourself and eligible dependents. Such continued coverage shall not be subject to evidence of insurability. You must pay the required group-rate premium in advance, but not more frequently than once a month. Supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

In the event that you are reemployed or restored to participating in the group on return to civilian status after the period of continuation of coverage or suspension, you and your covered spouse and dependents (if family coverage applies) shall be entitled to resume coverage under the Plan. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable premium has been paid from the date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding a condition that arose during the period of active duty and that has been determined by the secretary of veteran’s affairs to be a condition incurred in the line of duty.

---

**SECTION NINETEEN—Continuation of Coverage Under Cobra and Eligibility Under a Qualified Medical Child Support Order**

**COBRA.**

The term “COBRA” refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, which, as amended, provides you with the rights to health continuation coverage described in this Section.

**Qualified Beneficiary.**

A “Qualified Beneficiary” may be you or your spouse, Partner, or dependent child (collectively “family members”) who has health continuation rights with respect to an event that is a “Qualifying Event” for that person under the rules explained below.

Normally, one condition of a person being a Qualified Beneficiary is that the person has coverage on the day before the Qualifying Event.

As a limited exception to the Qualified Beneficiary rule above, a child who is born to or placed for adoption with you during a period that you have COBRA coverage also is considered a “Qualified Beneficiary.” The maximum COBRA period is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event—not the later date of the child’s birth, adoption, or placement.

**Type of Coverage That May Be Continued.**

The coverage that may be continued must be the same coverage in effect prior to the qualifying event, and may not be predicated on evidence of insurability. However, a Qualified Beneficiary who elects COBRA coverage may change coverage during the COBRA period under the circumstances that would allow an active employee to change coverage (e.g., during the annual enrollment period or due to a life status change during the year).

**Termination-of-Employment Qualifying Events for a Participant.**

You may elect COBRA coverage for yourself and covered family members, if coverage is lost because of your termination of employment or reduction in hours of employment (for reasons other than gross misconduct)—either of which is referred to a “Termination-of-Employment Qualifying Event.” These events are:

- Resignation;
- Discharge (except for gross misconduct);
- Illness;
- Plant closing, layoff or strike;
- Leave of absence; or
- Retirement.
Qualifying Events for a Spouse.
Your spouse may elect COBRA coverage for himself or herself (and any other affected family members) if coverage would end due to:
- A Termination-of-Employment Qualifying Event (see above);
- Your death;
- Your spouse’s divorce or legal separation from you; or
- Your entitlement to Medicare.

Qualifying Events for a Child.
A dependent child may elect COBRA coverage if coverage otherwise would end due to any of the qualifying events described above for a spouse, or if coverage would end because the child reaches age 26.

Notice Provisions; Election of COBRA Coverage.
- You (or a family member or legal representative) must inform Rensselaer within 60 days of the date of a divorce, a legal separation, or loss of dependent child status under the Plan. If timely notice is not given, the right to elect COBRA coverage on the basis of that qualifying event will be lost.
- Subject to the above notice first being given when it applies, Rensselaer will notify Qualified Beneficiaries of the right to choose COBRA health continuation coverage when a Qualifying Event occurs. The election for COBRA coverage must be made within 60 days from the later of the date of notification or the date of loss of coverage. If an election is not made within that time, coverage will end and there will be no further COBRA rights.

Cost of Continuation Coverage.
A Qualified Beneficiary who chooses COBRA coverage may be required to pay up to, but not more than, 102 percent of the full cost to the Plan for the coverage, except as provided for costs during a “disability extension period” (see below). The first premium payment must be made, with any payments owed from the date health coverage ended, within 45 days from the date the Qualified Beneficiary chooses to continue health coverage.

Length of Continuation Coverage.
A. A family member who is a Qualified Beneficiary may continue coverage for up to 36 months, if the Qualifying Event (as applicable) is your death, your entitlement to Medicare, divorce or legal separation, or a dependent child’s loss of dependent status.
B. You and your family members may continue coverage under COBRA for up to 18 months in the event you have a Termination of-Employment Qualifying Event. However, this period may be extended from 18 to 36 months, for the family members who have such COBRA coverage, if another Qualifying Event occurs during the initial 18-month period, or during a disability extension period that applies under the provisions explained below.

Example: If you resign, the 18-month continuation period applies. If your spouse is a qualified beneficiary with COBRA coverage on this basis, and you die after 3 months of continuation coverage, your spouse may choose to have 33 more months of coverage (36 months minus the 3 months of coverage already provided).

Note: Your Medicare entitlement will not be a Qualifying Event for family members if they keep their coverage because you are still employed. However, if they later lose coverage due to your termination of employment, their COBRA period will be 36 months measured from the earlier date that you became entitled to Medicare, if that is longer than an 18-month period measured from the Termination-of-Employment Qualifying Event.

Disability Extension Period.
The 18-month period for a Termination-of-Employment Qualifying Event may be extended from 18 to 29 months for all Qualified Beneficiaries entitled to COBRA coverage on the basis of that event, if any of them receives a determination of disability under the Social Security Act, finding that he or she became disabled within 60 days of the Qualifying Event. The Employer must be notified of the determination of disability within 60 days after the disability determination date and before the first 18 months of COBRA coverage ends.

During a disability extension period, the Plan may charge up to 150% of the premium as long as the disabled Qualified Beneficiary is part of the covered group. This higher limit applies if the 29-month period is extended to 36 months on the basis of another Qualifying Event that occurs during the disability extension period.

Termination of COBRA Coverage.
The COBRA coverage will end before the end of the applicable maximum time period in case of any of the following:
- Rensselaer ceases to provide health coverage to any employees;
- The premium for COBRA coverage is not paid in a timely manner, as determined under COBRA rules;
- The Qualified Beneficiary becomes covered (not merely eligible) under another group health plan after the date on which COBRA coverage is elected for the Qualified Beneficiary and either: (i) the other plan does not contain any exclusion

—37—
or limitation with respect to any preexisting condition of the Qualified Beneficiary; or (ii) the exclusion or limitation in the other plan either doesn’t apply to the Qualified Beneficiary or has been satisfied, based on applicable law;

• The Qualified Beneficiary becomes entitled to Medicare (not merely eligible for Medicare) after the date on which the COBRA coverage under the Plan is elected; or

• If the disability extension applies, there is a final determination that the Qualified Beneficiary is no longer disabled under the Social Security Act. Rensselaer must be notified within 30 days of the date of any final determination that the disability has ended. The extended health coverage will be terminated in the month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled.

QUALIFIED MEDICAL CHILD SUPPORT ORDER.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all the following:

• The order specifies your name and last known address, and the child’s name and last known address;
• The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
• The order states the period to which it applies; and
• The order specifies each plan that it applies to.

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

Eligibility for Coverage under a Qualified Medical Child Support Order (QMCSO).

If a QMCSO is issued for your child, he or she will be eligible for coverage as required by the order and you will not be considered a late entrant for dependent insurance. You must notify Rensselaer and elect coverage for that child within 31 days of the court order being issued.

Eligibility for Coverage for Adopted Children.

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for dependent insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in this Summary Plan Description that describe the requirements for enrollment and the effective date of insurance also apply to an adopted child or a child placed with you for adoption. (Refer to SECTION THREE—Who is Covered.)

SECTION TWENTY—General Information and ERISA Guidelines

As a Participant in the Rensselaer Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information about your Plan and Benefits.

Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage.

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries.**

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

**Enforce Your Rights.**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions.**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

---

**CLAIMS, COMPLAINTS and APPEALS**

**Filing Claims.**

For Medical Services and/or Mental Health or Chemical Abuse Services received from non-network Providers, claims for reimbursement must be submitted, with proof of payment, to CDPHN at the following address:

**Capital District Physicians’ Healthcare Network, Inc.**

P.O. Box 66602
500 Patroon Creek Blvd.
Albany, NY 12206-6602

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

**Resolving Differences.**

If you have a problem, talk with your physician, or call or write member services. Most problems can be solved right away. Problems that are not solved right away over the phone, and any complaints or appeals that come in the mail, will be handled according to the CDPHN complaint and appeal procedures described below.

---
Please note: If you have a complaint or appeal regarding the behavioral health benefits of your plan, contact the CDPHN-designated behavioral health organization at the number on your ID card. The CDPHN-designated behavioral health care organization follows the CDPHN processes in resolving differences for Plan Participants. In all cases, CDPHN is responsible for the final determination.

**How to File a Complaint.**

If you do not like some part of your Coverage (that does not involve a decision) you may file a complaint by calling or writing to CDPHN. You can also ask a designee (such as a lawyer, family member, or trusted friend) to file the complaint or appeal for you.

To file a complaint by phone, call the CDPHN Member Services department at (518) 641-3100 or 1-877-724-2579 Monday–Friday from 8 a.m. to 5 p.m. To file a written complaint, write CDPHN a letter, or call CDPHN at (518) 641-3100 or 1-877-724-2579 and request a complaint form. Complaint forms are also available on our Web site at www.cdphp.com under “Forms and Documents” at the bottom of the page.

Mail your complaint (form or letter) to:

**CDPHN Appeals and Complaint Department**

500 Patroon Creek Blvd.

Albany, NY 12206-1057

**What Happens Next?**

- Within fifteen workdays after CDPHN receives your complaint they will send you a letter to let you know that staff is working on your complaint. This letter will include the name, address, and telephone number of the individual who will answer your complaint. Qualified personnel will review your complaint, or if it’s a medical matter, a licensed, certified, or registered health care professional will investigate.

- Upon receipt of your complaint, CDPHN will request in writing any other information needed from you or your provider to decide your complaint. If only part of that information is provided, CDPHN will ask for the missing information, in writing, within five workdays of having received the partial information.

- CDPHN will give you or your designee a written decision on your complaint within 30 workdays after having received your complaint, or within 30 days after all needed information is received, whichever is first. If CDPHN does not have all the information needed to decide your case by the 30th workday; they will send you a letter explaining why a decision cannot be made. CDPHN will then make a decision based on the information available, and inform you of the decision within the next 15 workdays.

- If a delay would significantly increase the risk to your health, CDPHN will decide your case and provide a decision by telephone within 48 hours after receiving all needed information, or 72 hours after receiving your complaint, whichever is first. CDPHN will send you written notice of the decision in three workdays.

All written decisions on complaints also tell you how to appeal if you wish, and include any forms you may need.

**Benefit Coverage Determination**

You or your designee may file a request for benefit Coverage, or “claim,” either verbally or in writing, by calling or writing CDPHN for the following situations:

- Pre-service claims
- Reduction of Benefit Coverage
- Urgent decisions
- Extended course of treatment
- Post-service claims

**Pre-service claims**—A Pre-service claim is a request for care that 1) requires CDPHN Prior Authorization and 2) has not yet been provided to you. CDPHN will decide a pre-service claim request within 15 days after receiving the request for Coverage of services. If CDPHN does not have all the needed information to decide by then, it may take up to 15 more days to decide your case. CDPHN will send you a letter by the end of the first 15-day period, telling you why a decision cannot be made. You will be given 45 days to send the needed information.

**Reduction of Benefit Coverage**—CDPHN will advise in advance of any decision to reduce or end Coverage for ongoing care that was previously approved. You will be given enough time to appeal the decision and get a determination before Coverage for the benefit is reduced or ended.
Urgent decisions—An urgent (fast) decision can be made in cases where a delay could seriously endanger your life, health, or ability to regain the most function. (CDPHN uses the “prudent layperson standard” to decide if your situation meets these criteria.) CDPHN will also make an accelerated decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent care claim decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after receipt of your request. CDPHN will advise of the decision by telephone with written or electronic notice to follow within three days.

Extended course of treatment—If you ask to extend a course of treatment for urgent care beyond a previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account your medical needs. You will be told of CDPHN’s decision within 24 hours after your request has been received. Your request should be submitted to CDPHN a minimum of 24 hours before your course of treatment is scheduled to end.

Post-service claims—If your claim involves care that has already been provided (post-service claims), CDPHN will decide within 30 days from the receipt of your request. If CDPHN does not have all the needed information by the 30th day, it may take up to 15 more days to decide your case. CDPHN will tell you before the end of the first 30-day period what other information is needed and the date by which a decision is expected. You have 45 days from the time you receive CDPHN’s request to provide the information.

All Benefit Coverage Determination decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file an appeal.

Appeal Review:

If your appeal remains denied the case will automatically go to the CDPHN Appeal Committee who will make a decision either (a) for pre-service claims, 30 days from the date of receipt of your appeal; or (b) for post-service claims, within 60 days of receipt of your appeal.

- If the CDPHN Committee upholds the denial, you may have the right to an external review through an independent review organization if the denial involves a Medical Necessity, Experimental/Investigational decision, or CDPHN turned down your request for a service on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network. Your detailed Final Internal Adverse Determination letter will provide you with the necessary steps for requesting an external review. This letter will also include your ERISA rights.

- For appeals that are upheld by CDPHN Committee that do not involve Medical Necessity, Experimental/Investigational decision, or CDPHN turned down your request for a service on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network, a determination letter will be sent to you with your ERISA rights included.

What Happens Next?

With fifteen workdays of receipt, CDPHN will forward a letter to acknowledge receipt of your appeal. The letter will tell you the name, address, and telephone number of the person who is working on your appeal. If your case is a medical matter, a clinical peer reviewer who did not make the first decision will examine the case. If your case is not medical, a qualified person who is at a higher level than the person who made the first decision will be assigned.

- Upon receipt of your appeal, CDPHN will ask you or your provider for the information needed to decide your appeal. If you only forward some of the requested information, CDPHN will send you a letter within five workdays advising what other information is still needed.

- If your appeal involves a pre-service claim (a request for care not yet given), CDPHN will decide your appeal within 15 days of receipt for a medical necessity appeal and 30 days for an administrative appeal. If the appeal is denied the case will automatically go to the CDPHN Appeal Committee who will decide it within 30 days of receipt of the appeal.

- If your appeal involves urgent care claims, and a fast decision is needed, CDPHN will decide it as soon as possible, taking your medical needs into account, but no later than 72 hours after receipt of your appeal. CDPHN will advise of the decision with written or electronic notice to follow within three days.

- If your appeal involves post-service claims (care given in the past) CDPHN will decide it within 30 days from when your appeal is received. If the appeal remains denied the case would automatically go to the CDPHN Appeal Committee who will decide it within 60 days of receipt of the appeal.

All appeal decisions will tell you the specific reasons for the decision, any medical reasons for the decision.

Medical Records.

In order to process your claims under the Plan, it may be necessary for CDPHN to obtain your medical records and information from hospitals, physicians or other practitioners or other Providers who treated you. When you become covered under the Plan, you automatically give CDPHN permission to obtain and use those records and that information necessary to administer the Plan.
Health Insurance Portability and Accountability Act (HIPAA)

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. Under HIPAA, your employer is required to provide “Certificates of Prior Credible Coverage” for previous health insurance coverage. You may need to provide this certificate if medical advice, diagnosis, care or treatment was recommended or received for a condition within the six (6) month period prior to your enrollment in a new plan. When you become covered under another health plan, check with the plan administrator to see if you need to provide this certificate. You may need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll. In addition to establishing standards for electronic health care transactions and unique national identifiers, Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides the legal standards for the privacy and security of protected health information (PHI). PHI includes information that we have created or received about your past, present or future health or medical condition that could be used to identify you. All employee protected health information (PHI) is maintained in a manner consistent with the privacy standards established by HIPAA. Further, Rensselaer will provide you with a Notice of Privacy Practices, which describes how Rensselaer uses information about you and how you can access this information.

All employee protected health information (PHI), manual and electronic, shall be maintained in a manner consistent with privacy standards established by HIPAA.

SUMMARY PLAN DESCRIPTION INFORMATION

Plan Name: Rensselaer Polytechnic Institute Health Benefits Plan for Active Employees and Retired Employees. The Plan is also referred to as the Rensselaer Health Plan.

Employer and Plan Administrator: The Employer (“Rensselaer”) is also the “Plan Administrator” and “named fiduciary” for the Plan.

Employer Identification Number: EIN No. 14-1340095

Type of Administration: The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan.

Plan Type: The plan is an employee welfare benefit plan, as defined under the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Administrator and Agent for Service of Legal Process:

Curtis N. Powell, Vice President of Human Resources
Office of the Plan Administrator
Rensselaer Polytechnic Institute
110 8th Street
Troy, New York 12180

Plan Trustee: A list of any Trustees of the Plan is available upon request from the Plan Administrator.

Office of the Plan Administrator:

Curtis N. Powell, Vice President of Human Resources
Office of the Plan Administrator
Rensselaer Polytechnic Institute
110 8th Street
Troy, New York 12180
Telephone: (518) 276-6303

Claims Administrator:

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

Connecting You To The Right Resources: Looking for wellness support and advice? CDPHP® has a variety of programs that might help. Whether you are dealing with a serious health issue or simply looking for more ways to improve your health, call our single-source referral line—1-888-94-CDPHP (23747). Leave a confidential message, and a qualified professional will call you back with suggestions for CDPHP programs that can fulfill your unique needs.

CDPHP Behavioral Health Access Unit: Telephone number for triage, prior authorizations, or questions: 1-888-320-9584 • Fax number: (518) 641-3601. The line is staffed by clinical intake specialists weekdays from 8 a.m. to 6 p.m. Nights, weekends, and holidays, a staff member is on call.

—42—
**Rensselaer Plan Number:** Plan #521

**Plan Year:** January 1st through December 31st

**Collective Bargaining Agreements.** You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy is available from the Plan Administrator upon written request and is available for examination.

**Summary of Benefits.** The benefits available, as well as the procedures for presenting claims for benefits and for the redress of claims denied under the Plan are summarized in this summary plan description. Copies of this summary plan description are available without cost to any Participant in the Plan upon request and shall be provided to Participants.

**Funding.** The Employer and/or the Plan Participants fund the Plan through contributions.

**The 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 in 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.

**Amending and Terminating the Plan.** If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

Rensselaer presently intends to maintain the Plan in the future; 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. Any such amendment or termination shall be adopted by formal action of the Human Resources Department who is authorized to act on behalf of Rensselaer.

**Right to Amend.** Rensselaer reserves the right to modify or amend any or all of the provisions of the Plan, in whole or in part, at any time and from time to time, by action of the Board of Directors or through its duly authorized officer.

Anything in the Plan to the contrary notwithstanding, but consistent with applicable law, Rensselaer in its sole discretion may make any modifications or amendments, addition or deletion in the Plan, as to benefits or otherwise, and retroactively if necessary, and regardless of the effect on the rights of any particular Participants, which it deems appropriate in order to bring the Plan into conformity with or to satisfy the conditions of any applicable provisions of ERISA, the Code or regulations promulgated thereunder.

**Right to Terminate.** Rensselaer, acting through its Board of Directors or duly authorized officer, may terminate the Plan at any time by written instrument.

Rensselaer, pursuant to the terms of the group insurance contract, may amend or terminate any one of all of the group insurance contracts through which benefits are provided under the Plan.