Rensselaer HMO
Summary Plan Description
Your guide to Rensselaer's HMO benefits
THE RENSSELAER HMO PLAN

Effective January 1, 2005

This booklet describes the benefits in effect as of January 1, 2005, under the Rensselaer Polytechnic Institute Health Benefits Plan for Active Employees and Retired Employees. The Plan is also commonly referred to as the Rensselaer HMO Plan.

This document is intended to comply with the 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></th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION—Plan Overview</td>
<td>2</td>
</tr>
<tr>
<td>SECTION ONE—Definitions</td>
<td>4</td>
</tr>
<tr>
<td>SECTION TWO—How The Plan Works</td>
<td>5</td>
</tr>
<tr>
<td>SECTION THREE—Who Is Covered</td>
<td>8</td>
</tr>
<tr>
<td>SECTION FOUR—Inpatient Care</td>
<td>9</td>
</tr>
<tr>
<td>SECTION FIVE—Outpatient Care</td>
<td>10</td>
</tr>
<tr>
<td>SECTION SIX—Rensselaer Health Plan Benefit Chart</td>
<td>12</td>
</tr>
<tr>
<td>SECTION SEVEN—Emergency Care</td>
<td>14</td>
</tr>
<tr>
<td>SECTION EIGHT—Home Health Care</td>
<td>14</td>
</tr>
<tr>
<td>SECTION NINE—Skilled-Nursing Facility Care</td>
<td>15</td>
</tr>
<tr>
<td>SECTION TEN—Hospice Care</td>
<td>15</td>
</tr>
<tr>
<td>SECTION ELEVEN—Private Duty Nursing</td>
<td>16</td>
</tr>
<tr>
<td>SECTION TWELVE—Prescription Drugs</td>
<td>16</td>
</tr>
<tr>
<td>SECTION THIRTEEN—Durable Medical Equipment, Prosthetics, Orthotics, and Hearing Aids</td>
<td>17</td>
</tr>
<tr>
<td>SECTION FOURTEEN—Exclusions</td>
<td>18</td>
</tr>
<tr>
<td>SECTION FIFTEEN—Coordination of Benefits (COB) and Subrogation</td>
<td>20</td>
</tr>
<tr>
<td>SECTION SIXTEEN—Termination of Coverage</td>
<td>23</td>
</tr>
<tr>
<td>SECTION SEVENTEEN—Continuation of Coverage (COBRA) and QMCSO</td>
<td>23</td>
</tr>
<tr>
<td>SECTION EIGHTEEN—General Information and ERISA Guidelines</td>
<td>26</td>
</tr>
<tr>
<td>IMPORTANT REMINDERS and URGENT CARE CENTERS</td>
<td>30</td>
</tr>
</tbody>
</table>
INTRODUCTION—Plan Overview

This booklet is intended to provide a Summary Plan Description of the Rensselaer HMO 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.

Within this document, the HMO Plan Medical Benefits may be referred to as “The 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 18 years of age or older, unless eligible under COBRA New York State continuation rules, a regular Rensselaer employee or a fixed-term employee with an appointment of at least 16 weeks and scheduled to work at least 20 hours per week, you are eligible to participate in the Rensselaer HMO 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 HMO 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. Participants age 65 and older must have Medicare Parts A and B.

Persons not entitled to coverage include:

a. Persons who do not work or reside in CDPHN’s Service Area, except for dependent children who are otherwise eligible for coverage.

b. Persons who are in the armed forces of any government other than for duty of 30 days or less.

How Much Does Coverage Cost?

Rensselaer pays a portion of the cost of Plan coverage if you are a full-time employee. If you work at least 1440 hours a year, but less than full time, Rensselaer pays a lesser portion of the cost. Your share of the cost of coverage will be paid on a pre-tax basis under the Rensselaer Section 125 Plan. If you are a part-time employee scheduled to work between 1040 and 1439 hours per year and at least 20 hours per week, you must pay the entire cost of coverage on a post-tax basis.

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.

HMO Plan Components and How They Work.

The Rensselaer HMO 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). CDPHN Network Provider directories are available from Human Resources.
The Primary Care Physician.

A Primary Care Physician (PCP) is the key to making the most of the Rensselaer HMO 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. Please notify member services within five days of your appointment with a new PCP to ensure current records and claims processing.

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.

Emphasis on Prevention.

Because the Rensselaer HMO Plan covers the cost of such services as routine check-ups, well-child visits, and preventive screenings such as mammograms, 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, you pay an office visit Copayment.

Comprehensive Coverage.

When you need specialty care, your PCP provides a Referral to 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, your PCP, with prior approval of the CDPHN Medical Director, or his/her designee, will refer you to a non-Network specialist and you will receive In-Network benefits for covered services.

Prescription Drugs.

Participants in the Rensselaer HMO Plan are able to purchase up to a 34-day supply of covered, prescription drugs at all network pharmacies for a single Brand or Generic copayment, as applicable.

Prescriptions by Mail.

There also is a prescription mail service benefit for Participants of the Plan 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) Brand or Generic Copayments as applicable. A brochure describing the prescription drug program is available at Human Resources.

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 SIXTEEN and SEVENTEEN—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 HMO 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).

• 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 sponsor'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.

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.

**Copayment.** A Copayment is a fixed amount you must pay for certain covered services you receive under the Plan.

**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 or divorce.
- 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).
- Involuntary 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 your spouse's employment.
Network Provider. A Network Provider is an individual who is a duly licensed physician or other health care professional; or a hospital or other facility properly licensed to provide the services it provides and which has agreed under contract with CDPHN to provide services to covered Participants.

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.

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. A physician’s assistant, or a nurse practitioner may be seen by a Participant but only when they are supervised by a network physician. They may not be selected as a Primary Care Physician. 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 provides 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 physician, he/she will work with the Participant to select a network specialist and will provide a Referral for care. Whenever a Participant receives services from a Network Provider or specialist without a required Referral or from a non-Network Provider, coverage will 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.

SECTION TWO—How The Plan Works

This booklet is the summary plan description for the Rensselaer HMO Plan for Active Employees and Retired Employees. The HMO Plan is also referred to as “the Plan” within this document. 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 HMO 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 small Copayment or Coinsurance for office visits and other In-Network services.

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.
Care Available Under The Plan.

Network benefits.

CDPHN has established a network of health care Providers who will provide health care services to persons covered under the Plan. In order for you to receive **benefits**, your services MUST meet the requirements below:

- Services must be provided by your Primary Care Physician; or
- Services provided by another Network Provider are authorized by your Primary Care Physician who provides a Referral to the Provider; or
- In the case of an Emergency, you receive care as described in SECTION SEVEN—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 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.

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 *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.

Primary Care Physician Coordination.

As a Plan Participant, you select one physician—a Primary Care Physician—to coordinate all covered health care needs provided in network. Primary Care Physicians provide medical care, maintain complete and accurate medical records, and refer Participants to 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. *With the exception of emergencies and self-refer preventive care, only care properly coordinated by your Primary Care Physician (with Referrals, as required) will be reimbursed.*

Credentialed Provider Network.

The HMO 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.
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. Please notify member services within five days of your appointment with a new PCP to ensure current records and accurate claims processing.

**Using the Referral System.**

An important part of managed care is the Referral. When you work with your Primary Care Physician using the Referral, care you receive from Providers other than your Primary Care Physician is tracked to be certain that you are receiving the most appropriate medical treatment for your needs. The Referral also 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, be sure to first get a Referral from your Primary Care Physician.* If you receive covered services from a Network Provider or specialist without a required Referral, your care will not be covered under the Plan benefits, except in the case of Emergency care.

**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, and certain identified medicines, durable medical equipment, or prosthetic devices. 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.*

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.**

**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.

For health services received from non-Network Providers (e.g. Emergency Services rendered outside the service area), claims for reimbursement must be submitted in accordance with the procedure set forth in SECTION EIGHTEEN, 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 The Plan, 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 or your marriage has been annulled. Proof of eligibility status will be required upon request by the Plan Administrator.
- Your same-gender domestic partner of at least 18 years of age, not related to you; not married to another; does not have another domestic partner; resides with you continuously for the period of time required by the Plan and intends to do so indefinitely.
- Your unmarried dependent children who are younger than 19 years of age (or to age 25 if a full-time student) as long as they are principally dependent upon you for maintenance and support, and not on active duty in the armed forces of any country.
- Your unmarried children who are 19 years of age or older and 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 qualifications 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.
- Your domestic partner’s children.

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 unless the qualifications outlined under “Other Children Covered Under the Plan” are met.

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.

Note: Coverage for the initial hospital stay for a newly born adopted infant is not provided if a natural parent has insurance or other coverage is available for the infant’s care.

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 SEVENTEEN—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—Inpatient Care

Medical Services While Hospitalized.

Under the HMO 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.

Inpatient Services Under the 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, services are not covered.

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, if there is no charge by the facility. If autologous (one’s own) blood, when associated with a scheduled, covered surgical procedure, it is covered.

Number of Days of Care.

Subject to the limitations on the number of days of care for mental health, substance abuse, and rehabilitative care, described below, benefits will be provided for any day the CDPHN Resource Coordination Department determines that hospitalization was medically necessary for the care or treatment of your condition, Illness, or Injury. Inpatient hospital maternity care is 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 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.

Limitations on Number of Days of Care.

Benefits for hospital care will be limited in the following cases:

A. Alcohol and Substance Abuse.

The HMO Plan provides inpatient benefits for alcohol and substance abuse detoxification. There are no visit limitations. Alcohol and Substance Abuse inpatient rehabilitation is not covered.
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;
- Up to 30 days per calendar year for treatment of acute mental health conditions including all facility, diagnostic and physician's charges.

C. 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 per calendar year.

Payments for Inpatient Care.

Admission to a network hospital must be preauthorized by CDPHN Resource Coordination. The Plan will pay benefits of 100% of the cost for the covered medical services rendered during the hospital stay (including detoxification and rehabilitation care). The Plan will pay 80% of the cost for covered mental health inpatient services.

SECTION FIVE—Outpatient Care

Outpatient Medical Services.

The HMO Plan covers outpatient medical services under the following conditions:

- Services must be rendered by your Primary Care Physician; or
- Services provided by another Participating Network Provider are authorized by your Primary Care Physician who provides a Referral to the Provider;
- The service must be medically necessary;
- In the case of an Emergency, you receive care as described in SECTION SEVEN—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 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.

Office Visits.

The Plan will provide benefits for office visits to your Primary Care Physician for treatment of Illness, disease, and Injury. The Plan provides benefits for office visits and services of a network specialist, when your Primary Care Physician generates a Referral to the specialist. Remember, services provided by anyone other than your Primary Care Physician (or designated OB/GYN) require a Referral in order to be covered. The exception to this is Emergency services or a service designated as self-referral.

Benefit Detail.

Refer below for detail on Preventive Care followed by an alphabetic list of selected outpatient medical services.

Preventive Care.

The HMO Plan provides benefits for preventive care services rendered by your Primary Care Physician or by another Network Provider for whom your PCP provided a referral as described below:

- Routine physical examinations—fully covered (over age 19/one exam per calendar year).
- Well-child care—fully covered.
  Visits by: 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months.
  Ages 2–19—one visit per year.
• *Routine Pap tests.* Copayment applies.
• *Immunizations*—fully covered—school, work and travel immunizations excluded.
• *Routine Mammograms*—fully covered.
• *Routine gynecological examinations*—copayment applies.
• *Routine eye examinations*—copayment applies; one exam per 24 rolling months. (Self-refer to participating provider.)
• *Routine hearing examinations*—copayment applies.

**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 while you are covered under the Rensselaer HMO Plan. A copayment applies. Prior authorization required from Resource Coordination. The service must be rendered within 12 months of the accident.

**Alcohol and Substance Abuse.** The Plan provides benefits for *outpatient* treatment of Alcohol and Substance abuse. Refer to SECTION FOUR for inpatient services and limitations on inpatient hospital stays. Inpatient rehabilitation excluded.

**Ambulance Service.** The Plan will provide benefits for medically necessary emergency transportation by ambulance to the nearest facility qualified to provide the required treatment. A $50 copayment applies. Air Ambulance is reviewed on a case by case basis for medical necessity. Nonemergent intra-facility transport does not take a copayment.

**Blood.** The Plan provides benefits for blood, blood products, blood plasma, packed blood cells and blood platelets, if there is a charge from the facility. Storage of blood or blood products is excluded. The Plan 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. A visit copayment applies.

**Diagnostic X-ray, Laboratory Examinations and other Outpatient Diagnostic Tests.** The HMO 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. A copayment applies. Copayment waived at designated CDPHN preferred providers.

**Family Planning Services.** Voluntary Family Planning counseling is *covered* if provided by member's PCP or designated OB/GYN. IVF, GIFT, etc., reversal of voluntary sterilization, and sperm or ovum banking are *not covered.* Sterilization is covered under the surgery benefit. Artificial insemination is covered. Donor fees related to artificial insemination are excluded.

**Mental Health Care Visits.** The Plan will provide benefits for *outpatient* mental health care visits. Refer to SECTION FOUR for inpatient services and limitations on inpatient hospital stays. Refer to SECTION SIX—Benefit Grid for Individual and Group Therapy detail.

**Office Visits.** The Plan will provide benefits for office visits to a physician for the treatment of Illness, disease, Injury, or a condition. Copayment applies per visit.

*Note:* If a service is specifically covered under another Paragraph of this SECTION FIVE, 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, Postnatal and 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. Delivery is fully covered, when preauthorized as required.

**Second Surgical Opinion.** Second Medical Opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. Such Coverage shall include a second medical opinion from a non-Participating Provider specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, at no additional cost to the Participant beyond what the Participant would have paid for services from an appropriate Participating Provider specialist. The attending Participating Physician must provide a written referral to the non-Participating Provider specialist and the services are subject to prior written approval by CDPHN's Medical Director or his/her designee. An office visit copayment applies.

**Surgery (Outpatient or Office).** The Plan will provide benefits for outpatient (ambulatory) surgery, or surgery in a physician's office including anesthesia. Copayment applies.
### RPI Benefit Grid for 2005—HMO Plans 2H (Actives), 2O (Retirees)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Dental</td>
<td>$10 copayment. Coverage for accidental injury to sound teeth within 12 mos. of the accident. Prior authorization required from CDPHN Resource Coordination.</td>
</tr>
<tr>
<td>Allergy</td>
<td>1. Testing $10 copayment. 2. Immunotherapy No copayment.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$50 copayment. By a certified service includes evaluation &amp; treatment of emergency medical condition. No copayment for inter-facility transport.</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>No copayment. Covered in full.</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Chemical Abuse and Dependency—Contact</td>
<td>No copayment. No deductible. No coinsurance. Detoxification only. Rehabilitation is not covered.</td>
</tr>
<tr>
<td>Chemotherapy, Inhalation &amp; Radiation Therapy—OP</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>1. DME $10 copayment per item. Prior authorization required from Resource Coordination/items over $250. Copayment = lesser of 20% coinsurance/item or $10 copayment.</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>2. Supplies or Insulin or Oral Agents $10 copayment.</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>3. Self-Mgmt Education $10 copayment for medically necessary, relating to diet for persons w/diagnosis of diabetes.</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>$10 copayment. Waived if performed at a preferred provider location.</td>
</tr>
<tr>
<td>Dialysis &amp; Hemodialysis—Facility &amp; Physician</td>
<td>$10 copayment. Home dialysis requires prior authorization required from CDPHN Resource Coordination.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)—Includes Prosthetics &amp; Orthotics</td>
<td>20% coinsurance. Prior authorization required from CDPHN Resource Coordination for items over $250. Must be ordered by a par provider.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$50 copayment. Waived if admitted within 24 hrs. for same accidental injury/illness.</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>1. Routine $10 copayment. 2. Sick Eye $10 copayment.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>1. Basic Infertility $10 copayment for diagnostic testing &amp; treatment of infertility when rendered by designated OB/GYN. 50% coinsurance. Examples include tubal surgery, artificial insemination, sperm washing, post-coital exam, &amp; varicocele surgery.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>2. Advanced Infertility</td>
</tr>
<tr>
<td>Frames, Lenses and Contacts</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Gynecological Exam</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>HIV Counseling &amp; Testing</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>In lieu of hospitalization, covered in full. Must be ordered by par physician. Prior authorization required from CDPHN Resource Coordination.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Bereavement Counseling</td>
</tr>
<tr>
<td>Hospital</td>
<td>2. OP $10 copayment. No copayment. No deductible. No coinsurance. Medically necessary, and administered by the PCP. Travel not covered.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No copayment. No deductible. No coinsurance.</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>See Family Planning benefits.</td>
</tr>
</tbody>
</table>

---

---
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Services</td>
<td>$10 copayment waived when services are performed at a preferred facility.</td>
</tr>
<tr>
<td>Mammograms</td>
<td>No copayment. No deductible. No coinsurance.</td>
</tr>
<tr>
<td>Maternity</td>
<td>No copayment. No deductible. No coinsurance. Prior authorization required from CDPHN Resource Coordination. Visit 1 only: $10 copayment to determine pregnancy. Then no copayment, no deductible, no coinsurance.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>20% coinsurance. Limited to 30 days/calendar year. Prior authorization required from CDPHN Resource Coordination for Inpatient Services. Visits 1-4: $10 copayment each. Visit 5-20: $35 copayment each. Visits 1-4: $10 copayment each. Visit 5-20: $15 copayment each. 20 visit maximum, combined group OP and individual OP.</td>
</tr>
<tr>
<td>Newborn Care—In Hospital</td>
<td>No copayment. No deductible. No coinsurance.</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$10 copayment. Limit one course of 120 days or less/diagnosis/calendar year.</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>No copayment. No deductible. No coinsurance. Donor hospitalization covered. Prior authorization required from Resource Coordination. Bone Marrow searches limited to 10 individual potential donors per bone marrow transplant. Travel, food and lodging excluded for donor and recipient.</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Physical—Routine (beyond age 19)</td>
<td>No copayment. No deductible. No coinsurance. Limit 1x/calendar yr.</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$10 copayment. Limit one course of 120 days or less/diagnosis/calendar year.</td>
</tr>
<tr>
<td>Physician Visit</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Routine Not covered. Medically Necessary $10 copayment.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Active Employees: Retail up to a 34-day supply $10 generic/$25 brand Retirees: Retail $10 generic/$10 brand Active Employees: Mail Order up to a 90-day supply for two (2) copayments. ($20 generic/$50 brand.) Retirees: Mail Order up to a 90-day-supply for two (2) copayments. ($20 generic/$60 brand.)</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>20% coinsurance when medically necessary. Prior authorization required from CDPHN Resource Coordination. Must be ordered by a par provider.</td>
</tr>
<tr>
<td>Radiology</td>
<td>$10 copayment. Waived when services are preformed at a preferred facility.</td>
</tr>
<tr>
<td>Rehabilitation—Medical</td>
<td>No copayment. No deductible. No coinsurance. Prior authorization from CDPHN Resource Coordination required for inpatient rehabilitation services, 60 days per calendar year maximum.</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>$10 copayment.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>No copayment. No deductible. No coinsurance. Limit 90 days/calendar year in a semi-private room in lieu of further hospitalization. Must be ordered by par provider for the same accidental injury/illness. Prior authorization required by CDPHN Resource Coordination.</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$10 copayment. Limit one course of 60 days or less/diagnosis/calendar year.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Follow Surgery benefits.</td>
</tr>
<tr>
<td>TMJ—Dental</td>
<td>Covered if non-dental in nature.</td>
</tr>
<tr>
<td>Urgent Care Visits</td>
<td>$25 copayment at par facility. Also covered for follow-up specialist services rendered out of the service area. Requires CDPHN authorization.</td>
</tr>
<tr>
<td>Well Child Care—to age 19</td>
<td>No copayment. No deductible. No coinsurance. Limit 1 visit/at age 2 wks., 1 month, 2, 4, 6, 9, 12, 15 &amp; 18 mos. Limit 1 visit/yr. for ages 2-19.</td>
</tr>
</tbody>
</table>
SECTION SEVEN—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, the Plan will cover 100% of the Allowed Charge after payment of the $50 copayment for the licensed ambulance service. Ambulance services must be medically necessary resulting from an emergency or used for non-emergency inter-facility transport.
- Dental Services. The Plan will provide Emergency care immediately following trauma to sound, natural teeth consisting of trauma care, reduction of swelling, and pain relief, when authorized by your Primary Care Physician.
- Exclusions. Emergency benefits cover sudden onset of life-threatening illness or injury in the CDPHN service area or out of the service area. However, the Plan will not pay for Emergency care outside of the CDPHN service area in the following situations: care you could have foreseen before leaving the CDPHN service area; follow-up services (to Emergency care) that can be delayed until you return to the CDPHN service area without damage to your health.

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

You are entitled to medically appropriate Emergency care at an Emergency room of a hospital, regardless of geographic location. Facility and Physician (professional) Emergency services are covered at 100% of the Allowed Charge after payment of the $50 emergency copayment. No referral is required.

Services that are not medically necessary are not covered.

SECTION EIGHT—Home Health Care

Conditions for Home Health Care.

Under the Plan, benefits will be provided for home health care visits authorized by your CDPHN Primary Care Physician with prior 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.

Personnel Providing Home Health Care.

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

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

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

**Number of Home Health Care Visits.**

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

**Payments for Home Health Care.**

The Plan will pay benefits of 100% of the Allowed Charge. Pre-authorization of services is required.

---

**SECTION NINE—Skilled-Nursing Facility Care**

Under the Plan, 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.

**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 for up to 90 days per calendar year in a semi-private room, on any day the CDPHN Resource Coordination Department determines that confinement in a skilled-nursing facility is medically necessary for the care or treatment of your illness, disease, or injury. Benefits will not be provided after the date the CDPHN Resource Coordination Department determines that confinement no longer is medically necessary.

**Payments for Skilled-Nursing Care.**

- The Plan will pay benefits of 100% of the Allowed Charge. Pre-authorization of services is required.

---

**SECTION TEN—Hospice Care**

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

**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.
Hospice Care Benefits.

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

- Bed patient care either in a designated hospice unit or in a regular hospital bed;
- Day care services provided by the hospice organization;
- Home care and outpatient services that are provided by the hospice organization and for which the hospice organization charges you;
- Bereavement counseling (up to five family visits either before or after terminally ill member’s death) for the patient and the immediate family by a licensed social worker or licensed pastoral counselor;
- Coverage limited to 210 days inpatient and outpatient combined.

Payment for Hospice Care.

- The Plan will pay In-Network benefits of 100% of the Allowed Charge.

SECTION ELEVEN—Private Duty Nursing

Under the Plan, benefits will be provided for private duty nursing care when medically necessary, rendered in the hospital 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.

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.

- The Plan will pay In-Network benefits of 80% of the Allowed Charge. Pre-authorization of services is required.

SECTION TWELVE—Prescription Drugs

Prescription Drugs.

Subject to the General Provisions and Exclusions stated below, the Plan will provide benefits for prescription drugs (legend drugs), which by law can only be dispensed when they are ordered by a physician or other duly licensed health care provider legally authorized to prescribe drugs under Title Eight of the Education Law. This includes medically necessary enteral formulas which have been proven effective for the treatment of disorders such as phenylketonuria (PKU) if prescribed by a physician or other duly licensed health care provider. Prescription contraceptive injectables and prescription contraceptive drugs are covered.

Diabetic Supplies.

Diabetic supplies (including blood glucose strips, lancets, alcohol swabs), tubing, and insulin syringes/hypodermic needles used by insulin-dependent participants are covered under the Rx benefit. The Plan also will provide benefits for insulin. The Rx copayment or coinsurance applies.

General Provisions.

a) The maximum supply shall be limited to a 34-day supply, or the amount prescribed by the physician or duly licensed health care provider, or the commonly accepted unit of use, whichever is less. Benefits for most maintenance prescription drugs for up to a 90-day supply may be obtained through the CDPHN Mail Service Program and are subject to two copayments (see payment info below).

b) Whenever a drug has been prescribed in its generic form, the most cost-effective agent must be dispensed. Unless noted otherwise by the prescribing provider, generic substitution is permitted and encouraged in accordance with applicable state law whenever available even if the drug has been prescribed by brand name.

c) For the purposes of this coverage, “generic” Prescription Drugs are those defined as “generic” by the CDPHN designated pharmacy benefits manager. “Brand” Prescription Drugs are those defined as “brand” or “non-generic” by the CDPHN pharmacy benefits manager.

d) Compounded medications must contain at least one legend ingredient.

e) Enteral formula prescriptions are subject to prior approval by CDPHN. Prescription drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein, which are medically necessary. Coverage for such modified food products for any calendar year or for any
continuous period of 12 months for any Participant shall not exceed $2,500. Participants may contact Member Services or may consult the CDPHN Web site at www.cdphp.com to determine whether prior authorization is required.

f) The Participant must present a signed prescription for the drug from his/her Primary Care Physician, another Participating Provider, or a non-Participating Provider if prior approved by CDPHN's Medical Director, or his/her designee at the time he/she receives the initial supply of a covered prescription drug.

g) Coverage is subject to the CDPHN prescription drug formulary that is in effect on the date the prescription is filled. Certain drugs may be subject to prior approval. Participants may contact Member Services or may consult the CDPHN Web site at www.cdphp.com to determine whether an individual prescription drug is excluded from coverage and/or requires prior authorization.

h) Certain covered prescription drugs that are prescribed generally to promote increased quality of life and are not generally prescribed for daily use to treat a potentially life-threatening or disabling progressive medical condition may be limited in coverage based on medical necessity. All requests for potentially non-medically necessary supplies of these drugs will be subject to CDPHN’s Utilization Review process, including all avenues of appeal.

Exclusions.

The following are not covered under the Plan:
A. Non-legend (over-the-counter) drugs, or any drug not requiring a prescription;
B. Experimental and/or investigative drugs. All determinations regarding requests for potentially experimental and/or investigative drugs will be subject to exclusions and claims/appeals procedures;
C. Certain single-entity and combination products that have questionable effectiveness under the Federal Drug Administration’s Drug Efficacy Study Implementation (DESI) program;
D. Injectables that usually ARE self administered are covered under pharmacy benefits on the Plan. Injectables that usually ARE NOT self administered are covered under medical benefits on the Plan;
E. The administration of covered medication;
F. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in: a hospital, skilled-nursing facility, convalescent hospital, inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
G. Immunizing agents, biological serums, or allergy serums;
H. Devices of any type, such as, but not limited to, therapeutic devices or appliances, including support garments, other non-medical substances, regardless of intended use;
I. Hypodermic needles, syringes, (except for insulin-dependent persons);
J. Contraceptive devices;
K. Retin A (unless prescribed for acne treatment and documented by a physician on prescription);
L. Any drug, medicine, or medication used for cosmetic purposes;
M. Drugs used in connection with a non-covered service or a non-covered benefit; and
N. Refills if needed due to loss or misuse of supply, even if the refill is ordered by the provider.

Payment for Prescription Drugs.

- The Plan will pay In-Network benefits for a prescription or refill when written for up to a 34-day supply, by a Network physician and obtained from a participating pharmacy. Active employees pay a $25 Copayment for each Brand Name prescription drug or refill and a $10 Copayment for each generic-equivalent prescription or refill. Retirees pay $30 for each Brand Name prescription drug or refill and a $10 copayment for each generic-equivalent prescription or refill.
- The Plan will pay Mail Service benefits for a prescription or refill for up to a 90-day supply for two Brand or Generic copayments, as appropriate. An Active employee will pay $20/Generic or $50/Brand; a Retiree will pay $20/Generic or $60/Brand for mail order.

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

The Plan will provide benefits for durable medical equipment, prosthetic appliances, and orthotics described below when they are prescribed by a participating provider. CDPHN resource coordination prior authorization is required for items over $250.

Durable Medical Equipment, Prosthetic Appliances, Orthotics.

The use of the equipment/appliance must be directly related to the treatment of your condition. Durable medical equipment is equipment that is intended for repeated use and is not generally useful to a person in the absence of illness or injury. The equipment must be of a kind that generally is used only to treat a medical condition. The equipment will 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, replacement and necessary maintenance if covered under manufacturer’s warranty or purchase agreement. See SECTION FOURTEEN—Exclusions for more detail. Supplies included in the rental or purchase fee are covered. Coverage is provided for standard equipment only. 20% coinsurance applies.
Orthotics.

Orthotic Devices are rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. CDPHN will provide Coverage for the purchase of medically necessary orthotic devices subject to the same criteria as set forth in DME coverage above. There is no Coverage for orthotic shoe inserts. 20% coinsurance applies.

Prosthetic Appliances.

Prosthetic Devices are devices which replace all or part of a body organ, or replace all or part of a permanently inoperative, absent or malfunctioning body part, including but not limited to, artificial limbs, eyes, and post-mastectomy breast prostheses. CDPHN will provide Coverage for the purchase of a particular prosthetic device once during a member's lifetime. See above for repair, replacement and maintenance policy. 20% coinsurance applies.

Hearing Aids.

Not covered.

Oxygen.

Medically Necessary oxygen is Covered, subject to the same criteria as set forth for DME, Orthotics, and Prosthetics above. 20% coinsurance applies.

Diabetic DME Services.

Diabetic DME—Medically Necessary Durable Medical Equipment such as injection aids, insulin pumps, glucometers and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors (including non-invasive, subcutaneous or monitor implants) and blood glucose monitors for the legally blind are covered. CDPHN Resource Coordination Pre-authorization required. (Certain equipment and/or devices may not be subject to the prior authorization requirement.) $10 copayment per item applies.

Diabetic Pharmaceuticals—Includes Insulin and oral agents for controlling blood sugar. Must be obtained through a pharmacy. $10 copayment or 20% coinsurance per item, whichever is less applies.

Diabetic Supplies—Includes test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, insulin pump supplies, and cartridges for the legally blind. $10 copayment or 20% coinsurance per item, whichever is less applies.

Diabetic Education—Diet and/or self-management education provided by the physician or his/her staff as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician. $10 copayment per visit applies.

Payments for Durable Medical Equipment, Orthotics, Prosthetic Appliances and Oxygen.

- The Plan will pay benefits of 80% of the Allowed Charge for covered services.
- The Plan will pay benefits for Diabetic DME: $10 copayment; and for diabetic drugs and diabetic supplies: $10 copayment or 20% coinsurance applies, whichever is less.
- The Plan will pay benefits for diabetic education. $10 copayment applies.

SECTION FOURTEEN—Exclusions

1. Any Accidental Injury or illness for which benefits, settlement(s), award(s) or damages are received or payable (or could reasonably be expected to be received or payable if a claim were made) 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.
4. Any Health Services rendered after the termination of Coverage, except when a Participant is determined to be eligible for benefits under the continuation of Coverage provisions of the Plan.
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, except for supplies associated with Covered devices or equipment that are included in the rental fee or purchase price of the device or equipment.

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 CDPHN’s Medical Director or his/her designee for Participants whose future growth prohibits necessary treatment from being performed within 12 months of the Accidental Injury.

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 CDPHN’s Resource Coordination 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. 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.

10. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as “Procedures”) not proved to be safe and/or efficacious, or, because of a Participant’s condition, an efficacious procedure that will have no effect on the outcome of the Participant’s illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized United States authorities or United States governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Procedures that are ineffective or are in the stage of being tested or researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a particular illness, injury or disease which have received approval from the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment are Covered. Nothing herein shall be interpreted to preclude the application of Insurance Law Section 4303 regarding cancer drugs. CDPHN’s Medical Director or his/her designee shall determine issues of Coverage raised under this Paragraph.

11. Health Services received from a non-Participating Provider unless recommended by a Participant’s Primary Care Physician with CDPHN’s prior written approval, except in an Emergency.

12. The expense of purchasing or fitting eyeglasses or contact lenses.

13. The expense of purchasing or fitting hearing aids.

14. 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.

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

16. Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research, travel, school or camp.

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

18. 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.

19. 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.

20. Travel and transportation expenses even though prescribed by a physician.

21. Inpatient and outpatient Hospital services, unless arranged in advance by a Participating Physician or Medically Necessary because of an Emergency, for a covered service.

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

23. 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.

24. Long-term Physical Therapy or long-term rehabilitation.

25. 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.

26. 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.
27. Orthotic shoe inserts and routine foot care. This includes services or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

28. Any Health Services resulting from a Participant’s commission of a felony.

29. Non-Medically Necessary custodial care or rest cures and services rendered for the convenience of a Participant or provider.

30. 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.

31. Services required by an employer.

32. Payment will not be provided for services rendered in connection with an inpatient stay or portion of an inpatient stay for drug or alcohol addiction rehabilitation.

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

34. Intensive weight loss programs.

35. 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.

36. Infertility services and assisted reproductive services, including, but not limited to, the following: in vivo fertilization; in vitro fertilization; ZIFT (Zygote Intrafallopian Transfer); GIFT (Gamete Intrafallopian Transfer); TET (Tubal Embryo Transfer); associated procedures, include gamete or embryo donation; services to maintain a pre-viable embryo including, but not limited to immunotherapy; all services 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.

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

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

39. 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 Resource Coordination 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) for donors of organs to be transplanted.

40. 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, 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, the Plan will provide benefits for as long as Emergency care, in CDPHN’s sole judgement, is necessary and until it is possible for the Participant to be transferred to a Participating Provider Hospital.

41. 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.

42. 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 Resource Coordination Review process including all avenues of appeals.

SECTION FIFTEEN—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.

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 example, the Physician accepts assignment so both the Plan and Medicare will base their calculations on the Medicare approved amount of $70.00.
Example (a)—In-Network payment for an office visit.

**Plan Benefit:** $10 copay and then 100% coverage.

**Physician:** charges $100

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

**The Plan pays $4.** 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 $10 copay + Medicare ($56) + $4 = $70.

**You pay:** $10 co-pay when the service is provided. You are not responsible for the difference between the physician charges and the Medicare Allowed Amount.

<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>$4</td>
<td>$10 Copay</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 example, the Physician does NOT accept assignment so, the Plan will base its calculations on the reasonable charges ($90), as they are less than the amount the Provider charged ($100). Medicare will base its calculations on the Medicare allowed amount ($70).

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

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

**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 SIXTEEN—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:

• On the last day of the month in which the member ceases to be eligible as a subscriber or dependent.
• 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 divorce or your marriage is annulled, your coverage will end on the last day of the month in which divorce or annulment occurs.
• If you are covered as a child your coverage will end on the last day of the month you marry or reach the age of 19 (or age 25 if full-time student), whichever occurs earlier, unless you are a handicapped child, as defined in SECTION THREE—Who Is Covered.
• On a date, as determined by CDPHN and Rensselaer, 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.

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 SEVENTEEN—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 SEVENTEEN—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 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 from you; or
- Your entitlement to Medicare.

**Qualifying Events for a Dependent 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 loses dependent child status under the terms of the Plan (e.g., because the child reaches 19 years of age or marries).

**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 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.)
As a Participant in the Rensselaer HMO 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.
Filing Claims.

For Medical Services received from non-network Providers (emergency services rendered outside of the CDPHN Service Area), 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 6602
Albany, NY 12206-6602
Telephone: 1-877-724-2579

For Mental Health Services received from non-network Providers (emergency services rendered outside of the CDPHN Service Area), claims for reimbursement must be submitted, with proof of payment, to Value Options at the following address:

Value Options
P.O. Box 1347
Latham, NY 12110
Telephone: 1-800-700-4824

For Alcohol and Substance Abuse Services received from non-network Providers (emergency services rendered outside of the CDPHN Service Area), claims for reimbursement must be submitted, with proof of payment, to St. Peter’s Behavioral Health Management at the following address:

St. Peter’s Behavioral Health Management
3 Mercy Care Lane
Guilderland, NY 12084
Telephone: 1-800-427-9025

• 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.

Denied Claims.

As claims administrator, CDPHN is expected to provide written notification to the Participant when a Referral, health care service or claim is denied. The format of the denial notice must be set forth in a manner calculated to be understood by the Participant and provide the following information:

• The specific reason or reasons for the denial;
• A description of any additional material or information necessary for the Participant to clarify his/her claim for benefits, and an explanation of why such material or information is necessary; and
• Appropriate information as to the steps that need to be taken if the Participant would like to appeal a claim denial.

Appeal/Complaint Process.

An appeal is a verbal or written request to change a decision made by CDPHN regarding 1) a denial of service; or 2) a denial of benefits for a service. Appeals must be submitted within 180 days after the member receives notification of the initial adverse determination (denial).

Denial of service may take the form of a Pre-Service claim, Concurrent Care claim or Post-Service claim.

• Pre-Service claim—any claim for a benefit that occurs in advance of obtaining medical care. (i.e., a request for a referral is denied or an approval of a service is denied before it is rendered.
• Concurrent Care claim—any claim for Continued, extended or additional services.
• Post-Service claim—any claim for a benefit that is not pre-service claim.

An expedited appeal—is an appeal of adverse determination (denial) involving:

• Continued or extended health care services, procedures or treatment, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider.
• An adverse determination in which the health care provider believes an immediate appeal is warranted (except any retrospective determinations).

A complaint—is a verbal or written expression of dissatisfaction related to the quality of care or service. Complaints or appeals may be filed verbally or in writing.
Appeal of a Pre-Service Claim Denial.

Upon receipt of an appeal for a pre-service claim, CDPHN will complete a two-level review of the case and provide written notification to the member of the appeal outcome within 30 days of receipt of the appeal for pre-service claims.

Appeal of a Post-Service Claim Denial.

Upon receipt of an appeal for a post-service claim, CDPHN will complete a two-level review of the appeal within 60 days. The member will receive written notification of the appeal outcome within 60 days of receipt of the appeal request.

**Expedited Review.**

In the event that a delay would significantly increase the risk to the member's health, an expedited review will be completed. Expedited determinations at each level will be made and notification provided to the member no later than forty-eight (48) hours after the receipt of all information or seventy-two (72) hours after receipt of the appeal, whichever is less.

The member may designate a representative to file complaints or appeals on his/her behalf. The notification of the determination for an appeal or complaint will be provided to the member, the member’s designee, and where appropriate, the member’s health care provider.

All acknowledgement and outcome letters will include the name, address, and telephone number of the individual designated to respond to the appeal or complaint.

CDPHN does not require the member to sign an acknowledgement or description of a verbal appeal or complaint.

**Missing Information.**

CDPHN will specify, in writing, any additional information required from the member or provider to resolve the appeal or complaint within 5 calendar days from CDPHN's receipt of the member's appeal or complaint. In the event that only a portion of such necessary information is received, CDPHN will request the missing information, in writing, within five (5) business days of receipt of the partial information.

The member or provider may submit additional information verbally or in writing at any point in the appeals process.

The Member Service Department is available from 8:00 a.m. to 5:00 p.m., Monday through Friday. The Member Service Department can be contacted at (518) 641-3100 or toll free at 1-877-724-2579. Hearing Impaired members may call (518) 641-4000.

All written determinations for appeals and complaints include the detailed reasons and the clinical rationale, if applicable, as well as a statement that a criterion that was relied upon to make an adverse determination will be provided free of charge upon the claimant’s request. Once the internal appeal process is exhausted, further appeal rights, if any will be defined by the group.

The member may also have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, (as amended) (ERISA) to challenge the decision.

**Final Appeal.**

If a Participant does not agree with the decision made by the CDPHN Appeals Committee, he/she has the right to request a review of that decision by Rensselaer. This is accomplished by submitting a written request to:

Office of the Plan Administrator—Human Resources
Rensselaer Polytechnic Institute
110 8th Street
Troy, New York 12180
Telephone: (518) 276-6303

**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.

---

**SUMMARY PLAN DESCRIPTION INFORMATION**

**Plan Name:** The Plan is referred to as the Rensselaer HMO 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.
Patroon Creek Corporate Center
1223 Washington Avenue
Albany, NY 12206-1057
Telephone: (518) 641-3100

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.
IMPORTANT REMINDERS

HMO PLAN:

A PCP REFERRAL IS REQUIRED FOR ALL SPECIALIST VISITS in order to receive benefits on the HMO Plan.

EXCEPTIONS:
- Routine annual eye exam
- Routine or medical OB/GYN visit to your listed OB/GYN provider.

QUICK REFERENCE—Capital Area Urgent Care Centers, as of June 2005.

Additional Urgent Care Centers may be found in the CDPHN Provider Directory, at “Find-A-Doc” on the CDPHN Web site www.cdphn.com. Select “Service Centers,” then select “Urgent Care Centers” or call CDPHN Member Services—1-877-724-2579.

ALBANY COUNTY

- Albany Memorial Hospital Urgent Care 600 Northern Boulevard, Albany, NY 12204 (518) 471-3221
- Community Care Physicians 711 Troy-Schenectady Road, Latham, NY 12110 (518) 783-3110
- First Care Delmar Capital Medical Care 363 Delaware Avenue, Delmar NY 12054 (518) 439-9911
- First Stop Medical Care 1971 Western Avenue, Albany, NY 12203 (518) 452-2597
- Newton Medical Associates 588 Loudon Road, Latham, NY 12110 (518) 785-2662
- Newton Medical Associates 1662 Central Avenue, Albany, NY 12205 (518) 869-9692

MONTGOMERY COUNTY

- Amsterdam Memorial Hospital 4988 State Highway 30, Amsterdam, NY 12010 (518) 841-3600

ONEIDA COUNTY

- Slocum-Dickson Medical Group P.C. 1729 Burrston Road, New Hartford, NY 13413 (315) 798-1400

OTSEGO COUNTY

- Foxnow Walk-In Healthcare 739 NYS Highway 28, Oneonta, NY 13820 (607) 431-5052

RENSSELAER COUNTY

- On-Call Medical Services 76 North Greenbush Road, Troy, NY 12180 (518) 286-3000
- Samaritan Hospital 2215 Burdett Avenue, Troy, NY 12180 (518) 271-3300
- Urgent & Primary Care Center 598 Columbia Turnpike, East Greenbush, NY 12061 (518) 479-5240

SARATOGA COUNTY

- Medicall Urgent Care Center 1 Tallow Wood Drive, Clifton Park, NY 12065 (518) 373-4444
- Wilton Medical Arts, Saratoga Hospital 3040 Route 50 N, Saratoga Springs, NY 12866 (518) 580-2273

SCHENECTADY COUNTY

- Newton Medical III 2727 Hamburg Street, Schenectady, NY 12303 (518) 356-7818

WARREN COUNTY

- Hudson Headwaters Health Center on Broad Street 100 Broad Street, Glens Falls, NY 12801 (518) 792-2223
- Hudson Headwaters Health Network Warrensburg Health Center 3767 Main Street, Warrensburg, NY 12885 (518) 623-2844