AMENDMENT TO CHAUTAUQUA COUNTY SCHOOL DISTRICTS' MEDICAL HEALTH PLAN

Effective January 1, 2011

The Chautauqua County School Districts' Medical Health Plan Summary Plan description is amended as follows:

1. The **Summary of Benefits** for the Indemnity Medical Plan, Point of Service Plan and Preferred Provider Organization Plan are deleted and replaced by those in **Exhibit A** attached.

2. Section III. A. 1., **Employee Eligibility,** third paragraph is deleted and replaced as follows:

Effective July 1, 2011, under Federal Law, coverage for adult children, regardless of marital status, is available through age twenty-six. The parent of the adult child will need to be enrolled in the appropriate tier of coverage prior to or at the date of enrollment of the adult child.

3. Section III. D. 1. **Major Medical Benefits-Key Features** is modified effective July 1, 2011 to add the following at the end of the section:

Preventative Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis, which means that copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The federal Department of Health and Human Services will develop these guidelines and expects to issue them no later than Aug. 1, 2011.

4. Section III. D. 3. (f) (2) **Second Cancer Opinion (Indemnity)** is deleted and replaced as follows:

The plan pays 80% of covered charges, after the deductible is met, for a 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. A second cancer opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer. The cost shall be the same for a plan participant seen by an out-of-network appropriate specialist as it is for a plan participant seen by an in-network appropriate specialist.

5. Section III. D. 3. (f) (13) **Well Child Care (Indemnity)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

6. Section III. D. 3. (f) (14) **Other Medical Services (Indemnity)** is modified to add the following:

The Plan pays 100% of covered charges for the following health care services when medically necessary:

- Chemoprevention of breast cancer (women only- service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening
- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening (women only)
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling
- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals (individuals 19-21 years old)- includes labs, routine vision and services related to preventative visit

- Abdominal Aortic Aneurysm Screening (men ages 65-75)

7. Section III. D. 4. **Pregnancy and Maternity (Indemnity)** is deleted and the following is substituted:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Home care services covered under the maternity benefit are not subject to deductibles, coinsurance or co-payments. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

8. Section III.E.1. **Description of Point of Service Benefit** is modified in the third paragraph as follows:

The out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers.

Preventive Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis **when such services are provided by an in-network provider**, which means that copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization

Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The federal Department of Health and Human Services will develop these guidelines and expects to issue them no later than Aug. 1, 2011.

Specialty Services. At the time of enrollment or thereafter, if you are diagnosed with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you must notify the Plan Administrator who will work with an in-network specialist or specialty care center who will provide and coordinate your primary and specialty care. Note: A *specialty care center* is a center accredited by a state or federal agency or by a voluntary national health organization as having special expertise in treating a specific, life-threatening disease or condition or degenerative and disabling disease or condition. If the Plan agrees that an out-of-network authorization is necessary, services will be provided at no additional cost to you beyond what would normally be paid to an in-network specialist or specialty care center.

Standing Referral. If you have a medical condition that requires ongoing care from a specialist, your primary care physician or OB/GYN will make the arrangements, and recommend a specialist for ongoing care. Please make sure you are being directed to an in-network health care provider.

Transitional Care. Transitional care begins when an in-network provider's contractual obligation to provide services to plan participants terminates. If you are a new participant and your health care provider is not in-network, you will be able to continue treatment with the same health care provider during a transitional period of up to 60 days from the effective date of enrollment. If you are a current participant and your health care provider should decide to leave the network, you may continue treatment with this same provider during a transitional period of up to 90 days.

9. Section III. E. 3. s. **Well Child Care (POS)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

10. Section III. E. 3. t. (11) **Other Services (POS)** is modified to add the following:

- Chemoprevention of breast cancer (women only- service should be performed as part of a consultation)
- Immunizations for adults 19+
- Cholesterol abnormality screening

- Chemoprevention of breast cancer (women only- service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening
- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening (women only)
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling
- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals (Adults)- includes labs, routine vision and services related to preventative visit.
- Abdominal Aortic Aneurysm Screening (men ages 65-75)

11. Section III. E. 4. **Pregnancy and Maternity (POS)** is deleted and the following is substituted:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may

be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

12. Section III.F.1. **Description of Preferred Provider Organization Benefit** is modified to add a new third paragraph as follows:

The out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers.

Preventive Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis **when such services are provided by an in-network provider**, which means that copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The federal Department of Health and Human Services will develop these guidelines and expects to issue them no later than Aug. 1, 2011.

Specialty Services. At the time of enrollment or thereafter, if you are diagnosed with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you must notify the Plan Administrator who will work with an in-network specialist or specialty care center who will provide and coordinate your primary and specialty care. Note: A *specialty care center* is a center accredited by a state or federal agency or by a voluntary national health organization as having special expertise in treating a specific, life-threatening disease or condition or

degenerative and disabling disease or condition. If the Plan agrees that an out-of-network authorization is necessary, services will be provided at no additional cost to you beyond what would normally be paid to an in-network specialist or specialty care center.

Standing Referral. If you have a medical condition that requires ongoing care from a specialist, your primary care physician or OB/GYN will make the arrangements, and recommend a specialist for ongoing care. Please make sure you are being directed to an in-network health care provider.

Transitional Care. Transitional care begins when an in-network provider's contractual obligation to provide services to plan participants terminates. If you are a new participant and your health care provider is not in-network, you will be able to continue treatment with the same health care provider during a transitional period of up to 60 days from the effective date of enrollment. If you are a current participant and your health care provider should decide to leave the network, you may continue treatment with this same provider during a transitional period of up to 90 days.

13. Section III. F. 3. s. **Well Child Care (PPO)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

14. Section III. F. 3. t. (11) **Other Services (PPO)** is modified to add the following:

- Chemoprevention of breast cancer (women only- service should be performed as part of a consultation)
- Immunizations for adults 19+
- Cholesterol abnormality screening
- Chemoprevention of breast cancer (women only- service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening
- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening (women only)
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling

- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals (Adults)- includes labs, routine vision and services related to preventative visit
- Abdominal Aortic Aneurysm Screening (men ages 65-75)

15. Section III. F. 4. **Pregnancy and Maternity** is deleted and replaced as follows:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

16. Section VII.B. **Claim Appeal Procedures** is modified to delete the first four paragraphs and substitute a new Section 1 as follows:

VII.B.1. **Grievance Procedure for Service or Coverage Denials (POS and PPO Plans Only)**

This section explains the procedure for filing a grievance with us regarding our service or your coverage under the POS or PPO Plans. This grievance procedure does not apply to disputes involving medical necessity or investigational treatment, and does not apply to the Traditional (Indemnity) Plan.

a. Filing the Grievance. If you do not agree with a decision we have made concerning your coverage under the POS or PPO Plan, you or a representative you designate may file a written request for a review of our decision within sixty (60) days after you receive the notice of our decision. Your request should contain the reasons why you do not agree with the decision and any additional pertinent information. Send your written request to the Chautauqua County School Districts' Medical Health Plan, P.O. Box 399, Jamestown, New York 14702-0339, Attn: Pam Frangione. If you do not agree with a decision we have made concerning referrals or covered benefits, you may file an oral (telephone) request for a review of our decision with sixty (60) days of receipt of our decision by contacting the Plan at 1-800-913-1615.

Within fifteen (15) days of receipt of the grievance, the Plan will provide you written acknowledgement of the grievance, including the name, address and telephone number of the party designated by the Plan to respond to the grievance. We will also advise you as to what information must be provided to us to make a decision on the grievance. Qualified personnel will review the grievance and, if the grievance involves clinical matters, such personnel shall include licensed, certified or registered health professionals as appropriate.

We will provide you or your designated representative written notice of the determination on your grievance within the following timeframes:

- Forty-eight (48) hours after we have received all necessary information when a delay would significantly increase the risk to a plan participant's health – in this case such notice shall be made by telephone directly to the plan participant followed by written notice within three business days;

- Thirty (30) days after the receipt of all necessary information in the case of requests for referrals or determinations as to whether a requested benefit is covered under this Plan document;

- Forty-five (45) days after the receipt of all necessary information in all other instances.

b. Appeal of a Grievance Determination. You or your designated representative shall have sixty (60) business days after receipt of notice of a grievance determination to file a written appeal to the Plan. Within fifteen (15) days of receipt of the appeal we or a party we designate will provide you written acknowledgement of the appeal, including the name, address and telephone number of the party handling the appeal and what information, if any must be provided in order for the Plan to make a decision.

The determination of an appeal on a clinical matter will be made by qualified personnel who did not make the initial determination, at least one of whom will be a clinical peer reviewer as defined New York Insurance Law Article 49. A determination of an appeal on a non-clinical matter will be made by qualified personnel at a higher level than the personnel who made the grievance determination.

A decision on the appeal of a grievance determination shall be made and notice will be provided to you or your designated representative within the following timeframes:

- Two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a plan participant's health;

- Thirty (30) days after the receipt of all necessary information in all other instances.

Our notice of determination on appeal will provide you the reason for the determination, and in cases where there was a clinical basis, the clinical rationale for the determination.

17. Section VII.B.1. **Utilization Review** Subsections a. – c. and d.(1)-(4) are deleted in their entirety and replaced with the following:

VII.B.2. **Utilization Review Procedure**

a. Prospective Reviews. If we have all the information necessary to make a determination regarding a prospective review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

b. Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which

benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims.

If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you (or your designee) and your provider of our decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information unless it is a prospective urgent claim for which the prospective urgent claim time frames are applicable.

When we receive a request for home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

c. Retrospective Reviews. If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

Notice of Adverse Determination. A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

d. Internal Appeals. You (or your designee) have up to 180 calendar days after you receive notice of the adverse determination to file an internal appeal.

We will decide internal appeals related to prospective reviews within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your

designee (and, where appropriate, your health care provider) within two business days after the determination is made, but no later than 15 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and, where appropriate, your health care provider) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, home health care services following an inpatient hospital admission, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours of receipt of the appeal request or two business days of receipt of the necessary information. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your internal appeal within 60 calendar days of receipt of the necessary information for a standard appeal (unless an extension is requested by the Plan as described below) or two business days of receipt of the necessary information for an expedited appeal shall be deemed a reversal of the initial adverse determination.

If the Plan determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

Your Right to an Immediate External Appeal. If we fail to adhere to the utilization review requirements described in this Plan document, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in this Plan document.

EXHIBIT A

SUMMARY OF BENEFITS

INDEMNITY MEDICAL PLAN SUMMARY	
Annual Deductible Single Family	Depends on your District $50 or $100 or $200 or $250 or $400 or $500 per individual $100 or $200 or $400 or $500 or $800 or $1000 per family
Annual Out of Pocket Maximum	$400 per individual or $300 per individual for participants in Option 4 of the Prescription Drug Plan
Ambulatory Care (Diagnostic X-ray and Laboratory)	100% of Reasonable & Customary (*R&C*) *– Please see definition on page 5 of Section I*
Inpatient Hospital	100% of R&C for up to 365 days per confinement
Inpatient Mental Health; Chemical Dependence or Abuse	100% of R&C
Outpatient Mental Health;	80% of R&C coverage after deductible
Ambulance Services	100% of R&C coverage
Chiropractic Care	80% of R&C coverage after deductible
Outpatient Chemical Abuse or Dependence Treatment	100% of R&C
Inpatient Physician	100% of R&C coverage
Outpatient Physician	80% of R&C after deductible
Surgery Physician Charges Facility Charges	 100% of R&C coverage 100% of R&C coverage
Supplemental Accident	100% of R&C for the first $500 resulting from an accident
Annual OB/GYN & Maternity Care	100% of R&C coverage for laboratory and test charges for pap smear – see Section III Medical Plan for further details
Well Child Care/ Preventative Primary Care	100% of R&C coverage (includes physicals for individuals 19-21 years old as well as labs, routine vision, and services related to preventative visit).
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	80% of R&C after deductible 100% of R&C coverage for chemoprevention of breast cancer (women only)
Preadmission Testing	100% of R&C coverage
Emergency Room	100% of R&C coverage
Home Care	100% of R&C coverage for up to 365 visits (4 hours equals 1 visit)
Second Surgical Opinion	100% of R&C coverage
Second Cancer Opinion	80% of R&C after deductible
Hospice Care	80% of R&C after deductible
Mammography Screening	100% of R&C coverage
Mastectomy	100% of R&C coverage
Breast Reconstruction after a Mastectomy	100% of R&C coverage
Infertility Treatment	100% of hospitalization, surgical care, laboratory tests, and FDA-approved drugs (subject to copay); 80% of medical care for the diagnosis

	of infertility
Diabetes Testing and Treatment	100% of R&C after deductible (no deductible applies to diabetes screening for adults 19+)
Diagnostic Screening & Treatment of Prostatic Cancer	100% of R&C coverage
Bone Mineral Density Measurements, Testing, and Treatment	100% of R&C coverage for men & women meeting eligibility requirements
Diagnosis & Treatment of Eating Disorders	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment
Diagnosis & Treatment of Autism Spectrum Disorder	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment
Abdominal Aortic Aneurysm Screening	100% of R&C coverage (men ages 65-75)
Immunizations	100% of R&C coverage (adults 19+)
Cholesterol Abnormality Screening	100% of R&C coverage
Depression Screening	100% of R&C coverage (adults and adolescents)
Congenital hyperthyroidism screen	100% of R&C coverage (children less than 1 year of age)
Hearing Loss Screening	100% of R&C coverage (children less than 1 year of age)
Flu Vaccinations	100% of R&C coverage
HIV Screening	100% of R&C coverage
Gonorrhea, Syphilis, and Chlamydia infection screen	100% of R&C coverage (women only)
Hepatitis B screening	100% of R&C coverage (women only)
Sexually Transmitted Infection (STI) Counseling	100% of R&C coverage (adults and adolescents)
Obesity Screening and Counseling	100% of R&C coverage
Healthy Diet Counseling	100% of R&C coverage (adults 19+)
High Blood Pressure Screening	100% of R&C coverage (adults 18+)
Phenylketonuria (PKU) Screening	100% of R&C coverage (newborns)
Sickle Cell Screening	100% of R&C coverage (newborns or infants less than 1 year of age)
Reduce Alcohol Misuse - Screening and Counseling	100% of R&C coverage
Drug Use Assessment Screening and Counseling	100% of R&C coverage
Tobacco Use Counseling	100% of R&C coverage (adults)
PRESCRIPTION DRUG PLAN	
Prescription through Medical Plan	80% of R&C after deductible
Prescription Drug card Option 1 Option 2 Option 3 Option 4 Option 5 Option 6 Option 7	 $1 copay $5 copay $5 copay for generics/$10 copay for brand drugs 20% coinsurance per prescription up to the first $100; then 100% coverage $7 copay $10 copay $5/$10 with $250 deductible

Option 8 Option 9 Option 10 Option 11 Options 12	$3/$10/$20 Copays $7/$15/$35 Copays $10/$20 Copays $10/$20/$40 Copays 20% Coinsurance per prescription up to the first $250, then 100% coverage
DENTAL PLAN	
Deductible	None
Maximums	$1,500 per year per person/ $1,000 lifetime orthodontia
Preventive/Diagnostic	90% of R&C coverage
Restorative/Endo/Periodontics	80% of R&C coverage
Prosthodontics	50% of R&C coverage
Orthodontia	50% of R&C coverage
VISION PLAN	
In Network Option A	100% coverage for exam, frames, and lenses after $15 copay. Services limited to once per 24 months.
In Network Option B	100% coverage for exam, frames, and lenses after $25 copay. Services limited to once per 12 months.
Out-of-Network	100% coverage up to scheduled maximum for exam, frames and lenses. Option A services limited to once per 12 months. Option B services limited to once per 12 months

This is a brief summary of the benefits available. A complete description of your benefits, including any additional provision or limitations is contained in the body of this document.

SUMMARY OF BENEFITS		
POINT OF SERVICE MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maxiumu	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible -
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full ($10 Copay if performed in a physician's office)	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventative Care Adult Physical Well Child Care – to age 19	$10 Copay Covered in full (includes physicals for individuals 19-21 years old as well as labs, routine vision, and services related to preventative visit)	No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay; Full coverage for chemoprevention of breast cancer (women only)	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-authorized. Covered in full; limited to 50 days per year regardless of in/out of network.	Must be pre-authorized. 80% of Fee Schedule after deductible

Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services
Home Care Services	$10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	
Mammography Screening	Covered in full	
Mastectomy	Covered in full	80% of Fee Schedule after deductible
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible
Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – See Part III for eligibility requirement	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Abdominal Aortic Aneurysm Screening	Covered in full (men ages 65-75)	80% of Fee Schedule after deductible
Immunizations	Covered in full (adults 19+)	80% of Fee Schedule after deductible
Cholesterol Abnormality Screening	Covered in full	80% of Fee Schedule after deductible
Depression Screening	Covered in full	80% of Fee Schedule after deductible
Congenital hyperthyroidism screen	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Hearing Loss Screening	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Flu Vaccinations	Covered in full	80% of Fee Schedule after

		deductible
HIV Screening	Covered in full	80% of Fee Schedule after deductible
Gonorrhea, Syphilis, and Chlamydia infection screen	Covered in full (women only)	80% of Fee Schedule after deductible
Hepatitis B screening	Covered in full (women only)	80% of Fee Schedule after deductible
Sexually Transmitted Infection (STI) Counseling	Covered in full (adults and adolescents)	80% of Fee Schedule after deductible
Obesity Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Healthy Diet Counseling	Covered in full (adults 19+)	80% of Fee Schedule after deductible
High Blood Pressure Screening	Covered in full (adults 18+)	80% of Fee Schedule after deductible
Phenylketonuria (PKU) Screening	Covered in full (newborns)	80% of Fee Schedule after deductible
Sickle Cell Screening	Covered in full (newborns and infants less than 1 year of age)	80% of Fee Schedule after deductible
Reduce Alcohol Misuse - Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Drug Use Assessment Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Tobacco Use Counseling	Covered in full (adults)	80% of Fee Schedule after deductible
PRESCRIPTION DRUG PLAN		
Prescription Drug Card	**Up to a 30 day Retail Supply**	
Option 5	$7 copay	
Option 6	$10 copay	
Option 7	$5/$10 with $250 deductible	
Option 8	$3/$10/$20 Copays	
Option 9	$7/$15/$35 Copays	
Option 10	$10/$20 Copays	
Option 11	$10/$20/$40 Copays	
Option 12	20% Coinsurance per prescription up to the first $250, then 100% coverage	
Option 13	$7/$15 copay	
Option 14	$5/$10/$25 copay	

** Member must select a Primary Care Physician (PCP) from the In-network Providers of the Medical Administrator** Out-of-Network benefits are paid by the Plan if a receives care from a non-participating provider.*

This is a brief summary of the benefits available. Not all districts offer all benefits. Please check with your district for your benefit eligibility. A complete description of the benefits, including any additional provision or limitations. contained in the body of this document.

SUMMARY OF BENEFITS PREFERRED PROVIDER ORGANIZATION MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT - PPO*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maximum	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible -
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible -
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full	 80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventative Care Adult Physical Well Child Care – to age 19	$10 Copay Covered in full (includes physicals for individuals 19-21 years old as well as labs, routine vision, and services related to preventative visit)	No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay; Full coverage for chemoprevention of breast cancer (women only)	80% of Fee Schedule after deductible
Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services

	services	
Home Care Services	365 Visits @ $10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-approved; Covered in full	Must be pre-approved; 80% of Fee Schedule after deductible
Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	Covers specialists' actual charges.
Mammography Screening	Covered in full	
Mastectomy	Covered in full	
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible
Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA approved drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – Where eligibility requirements are met.	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Abdominal Aortic Aneurysm Screening	Covered in full (men ages 65-75)	80% of Fee Schedule after deductible
Immunizations	Covered in full (adults 19+)	80% of Fee Schedule after deductible
Cholesterol Abnormality Screening	Covered in full	80% of Fee Schedule after deductible
Depression Screening	Covered in full	80% of Fee Schedule after deductible
Congenital hyperthyroidism screen	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Hearing Loss Screening	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Flu Vaccinations	Covered in full	80% of Fee Schedule after deductible
HIV Screening	Covered in full	80% of Fee Schedule after deductible
Gonorrhea, Syphilis, and Chlamydia infection screen	Covered in full (women only)	80% of Fee Schedule after deductible
Hepatitis B screening	Covered in full (women only)	80% of Fee Schedule after deductible
Sexually Transmitted Infection (STI)	Covered in full (adults and	80% of Fee Schedule after deductible

Counseling	adolescents)	
Obesity Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Healthy Diet Counseling	Covered in full (adults 19+)	80% of Fee Schedule after deductible
High Blood Pressure Screening	Covered in full (adults 18+)	80% of Fee Schedule after deductible
Phenylketonuria (PKU) Screening	Covered in full (newborns)	80% of Fee Schedule after deductible
Sickle Cell Screening	Covered in full (newborns and infants less than 1 year of age)	80% of Fee Schedule after deductible
Reduce Alcohol Misuse - Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Drug Use Assessment Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Tobacco Use Counseling	Covered in full (adults)	80% of Fee Schedule after deductible
PRESCRIPTION DRUG PLAN		
Prescription Drug Card	**Up to a 30 day Retail Supply**	
Option 5	$7 copay	
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Option 10	$10/$20 Copays	
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***Out-of-Network benefits are paid by the Plan if a member receives care from a non-participating provider.*

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