



Summary Plan Description

For the Employees of

UNION

C O L L E G E

Union College PPO Plan U

Effective January 1, 2015

Claims Administered by



Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd. • Albany, NY 12206-1057 • (518) 641-3000



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Introduction

Welcome

Welcome to the Union College PPO Plan U administered by Union College with claims administered by Capital District Physicians' Healthcare Network, Inc. (CDPHN). The Union College PPO Plan U is a comprehensive health benefits program, managed by an extensive network of providers that provides you with excellent health care. Because this system may be new to you, please take a moment and read this booklet carefully so that you may get the most from your Union College PPO Plan U health coverage. If you have any questions or need additional information, please call CDPHN at (518) 641-3100 or 1-877-724-2579. We look forward to serving you!

This booklet summarizes, in everyday language, the benefits under the Union College PPO Plan U ("Plan") and procedures you must follow.

The Plan document is available for examination at the Union College Human Resources Office. If any portion of this booklet shall, for any reason, be or become invalid or unenforceable, such portion shall be ineffective only to the extent of such invalidity or unenforceability and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect.

Please review this document carefully. Only those medically necessary health services listed are covered under the Plan. The fact that a physician has performed or prescribed a procedure or treatment, or that the procedure or treatment may be the only available treatment for an injury or illness does not mean the procedure or treatment is covered under the Plan.

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.

How The Plan Works

Network Benefits

The Union College PPO Plan U is a Preferred Provider Option (PPO) plan in which services are delivered through a two tiered approach.

- The first tier is through the CDPHN Network (or MagnaCare and First Health Network in outlying areas) rendering In-Network level of benefits.
- The second tier is through non-Participating Providers and Practitioners offering these same service at the Out-of-Network level of benefits. These services are subject to a deductible with a few exceptions.

Primary Care Physician and Referrals

When you enroll in the Plan, you do not need to select a Primary Care Physician ("PCP"), however you are encouraged to do so. With a primary care physician, you can feel secure knowing that one medical professional will be familiar with your medical history, maintain a complete medical record for you, and eliminate unnecessary duplication of costly laboratory tests and X-rays. Referrals are not required to visit a specialist.

High-Quality, Carefully Credentialed Provider Network—The Union College PPO Plan U offers a network of health care professionals to provide your medical care. The network consists of high-quality physicians and other medical professionals and facilities who work with you to keep you healthy, and provide quality care and treatment when you are ill or injured.

Evaluating and Maintaining High Quality—The quality health care services provided to Union College PPO Plan U participants must meet accepted high standards set by national medical organizations and CDPHN. CDPHN uses a team of nurses who work with the medical director and network physicians to implement these quality health care guidelines. In addition, medical review teams actually go on-site to physicians' offices and hospitals to review medical records for appropriate levels of care.

Non-Network Benefits

Your coverage also includes out-of-network benefits so you can see any provider you choose, even if he or she is not in the CDPHN network, however you will pay a larger share of costs and you may have to submit a claim with receipts for reimbursement. Note that out-of-network benefits differ from benefits that may be obtained in-network.

Out-of-Area Coverage

If you are outside the network service area (e.g., you are temporarily working, away at school or traveling out of town) you may receive network benefits if 1) you have a medical emergency

as defined under the Emergency benefit within the SPD; or 2) you receive prior authorization through CDPHN's Resource Coordination Department for non-emergency care.

- CDPHN reserves the right to require the student dependent to return to the CDPHN service area to obtain medically necessary services from participating providers, when the student dependent has an illness, injury or disease which results in:
 - Absence from classes for more than two (2) consecutive school weeks;
 - Or required continued medical treatment for more than 60 days.

Examples of covered services include Allergy injections; sick office visits; physical therapy for an acute condition; cast removal, etc.

Exclusions include non-emergency services during vacations and/or summer recess; routine well visits; annual exams; routine or ongoing prescriptions, etc.

Maximizing Your Benefits

The Union College PPO Plan U has been designed to provide you with high quality medical benefits that are also affordable. When you use the managed care system of in-network providers and referrals, you will be responsible for a small copayment for office visits and other in-network services. Also, because network providers have agreed to accept payment from the Plan as payment in full, you will not be responsible for paying any unpaid balances. However, when you use out-of-network providers, you will be responsible for your deductible, coinsurance and any amounts over the usual and customary rate.

Less paperwork is another benefit of using the managed care system. When you receive services from a network provider, the provider will complete and mail claim forms to CDPHN and reimbursement will be mailed directly to the provider.

When you use out-of-network providers, you will be responsible for mailing CDPHN a claim form.

Annual Deductible

The Union College PPO Plan U imposes a separate In-Network and Out-of-Network annual Deductible before the Plan provides benefits for certain services. The In-Network Deductible applies to all non-preventive services. The annual Deductible is the initial amount that must be paid by a Participant before the Plan covers any portion of that service. The deductible applies to each Participant enrolled on the Plan and starts over for each Participant, each Calendar Year (January 1 to December 31)—thus the name annual Deductible.

The annual Deductible applies separately to you and each of your Dependents covered by the Plan. Once a Participant's Deductible is paid in a Calendar Year, no further Deductibles will be taken for that Participant during that Calendar Year. The individual Deductible applies to each Participant for each coverage level. Once the Family Dependent dollar maximum has been met, the Plan benefits go into effect for all family members for the remainder of the Calendar Year, including those that may not have met their individual Deductible. However, no single family member may contribute more than \$400 toward meeting the In-Network Deductible and \$800 toward meeting the Out-of-Network Deductible.

Note:

- Participant Copayments (fixed visit fees) for Covered services are credited toward the Deductible.
- Participant Coinsurance payments for Covered services are not credited toward the Deductible.
- Participant payments in excess of the Allowed Charge (or Reasonable & Customary Charge) or Participant payments for services that are not covered by the Plan are not credited toward the Deductible.
- If a person covered by this plan changes status from Employee to Dependent or Dependent to Employee and the person is covered continuously under this plan, credit will be given for deductible and all amounts applied to benefit maximums.

Annual Out of Pocket Maximum

Once a Participant has paid an amount equal to their out-of-pocket maximum, the Plan will pay 100% of the Reasonable and Customary Charge for covered services for the remainder of the calendar year. The Union College PPO Plan U calculates a separate In-Network and Out-of-Network out-of-pocket maximum. Combined Medical and Prescription Participant cost shares apply to the In-Network out-of-pocket maximum. Only medical Participant cost shares apply to the Out-of-Network out-of-pocket maximum.

As long as your out-of-network charges are less than or equal to the Reasonable and Customary charge, you will not be responsible for any *additional* charges. However, if your out-of-network charges exceed the Reasonable and Customary charge, your provider may bill you for the additional charges. Charges above the Reasonable and Customary charge are not subject to the out-of-pocket maximum.

Reimbursement of Expenses

In-Network Services

Network providers are responsible for submitting to CDPHN a claim for eligible expenses for each service. In the event that a participant is billed by a network provider for eligible expenses, the participant should contact CDPHN at (518) 641-3100 or 1-877-724-2579 or in writing at 500 Patroon Creek Blvd., Albany, NY 12206-1057.

Claims Filing

For health services received from non-network providers, claims for reimbursement must be submitted in accordance with the procedure set forth below.

Any claim for reimbursement submitted by a covered participant shall be submitted, with proof of payment, to CDPHN at the following address:

Capital District Physicians' Healthcare Network, Inc.
P.O. Box 66602
Albany, NY 12206-6602

Timing

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 during 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 or Union College Human Resources. 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 covered participant be examined at the Plan Sponsor's expense by a physician designated by CDPHN.

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 is sought to be recovered.

Eligibility and Enrollment

Plan Participation

If you are a regular employee of Union College who is scheduled to work 20 hours or more per week and at least 660 hours per year, you are eligible to elect coverage. The effective date of your coverage will be the first of the month following date of hire or on your date of hire if it is the first of the month. If you elect not to enroll when first eligible, you may enroll during the group open enrollment period (November) for a January 1 effective date. Employees who retire or are placed on long term disability will be eligible for continuing coverage under the plan. Retirees or permanently disabled participants will not be allowed to re-enroll for coverage if they cancel coverage at any point. Coverage for Medicare eligible retirees is limited to special cases. Human Resources will confirm eligibility.

Actively at Work

If employment is the basis for coverage under the Plan, then the individual, including Scholarly Exchange Visitors, must have active work status with the employer on the date the coverage or any increase in coverage is to be effective. An individual is on active work status on any regular nonworking day if he/she is not totally disabled on that day and if he/she was on active work status on the latest regular working day before that day. If an individual is not on active work status on the date his/her coverage is to be effective, coverage will not begin until the date he/she does attain active work status.

Flex Open Enrollment Period

You are offered the opportunity to elect coverage for you and your family when you first become eligible to participate in the Plan and thereafter each fall during the annual open enrollment period. Your benefit coverages elected during the annual open enrollment period become effective January 1 immediately following the open enrollment period and must remain in effect for the entire plan year unless an otherwise qualifying event or change in family status occurs.

Dependent Separation Event

If a participant covered by this plan changes status from Dependent to Subscriber and the participant is covered continuously under this plan, credit will be given for deductibles and all amounts applied to benefit maximums.

Persons Who May Be Covered Under the Medical Plan

You may elect coverage for yourself. In addition you may elect coverage for:

- Your spouse.
- Your children to age 26 including students on a qualified medical leave.
- Your domestic partner.
- Surviving children.
- Surviving domestic partner or spouse.
- Your domestic partner's children to age 26 including students on a qualified medical leave.
- Scholarly Exchange Visitors.

Spouse

Your legally married husband or wife. Proof of a legally sanctioned marital relationship will be required upon request by the Plan Administrator.

Domestic Partner

Your domestic partner must meet all of the following:

- At least 18 years of age;
- Not related to the subscriber by marriage or blood;
- Not married to anyone else nor have another domestic partner; and
- Residing in the same household with the subscriber continuously for at least the time period agreed upon by the group and CDPHN (which in no case is greater than 12 months) and intending to do so indefinitely.

Children

Children under age 26: Children who are less than 26 years of age and are not on active duty in the armed forces of any country.

The term "children" includes natural children, children of domestic partners, adopted children or children placed with you in anticipation of adoption. Step-children who reside in your household may also be included. Children living with you who are related to you by blood or marriage, for whom you are the legal guardian, may also be included if you provide their sole support. In most cases, you will be required to submit evidence of the child's eligibility, including legal guardianship. Coverage ends on the last day of the month in which the child turns age 26.

Children age 26 or older: Coverage is available for children age 26 and older who cannot support themselves because of a physical or mental disability and who are primarily dependent upon you for support and maintenance. The Plan Administrator may require proof of the child's disability and dependency. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the medical Plan's expense, to determine the existence of such incapacity.

Qualified Domestic Relations Order of Support (QDROS): As required by the federal Omnibus Budget Reconciliation Act of 1993, any children of a covered person who are alternate recipients under a qualified medical support order (generally as the result of a legal separation or divorce agreement) maintains a right to receive coverage under this Plan subject to the terms of the qualified medical support order.

Qualified Medical Support Order (QMCSO): A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employee-sponsored group health plans to extend health care coverage to children of an employee who is divorced, separated, or never married when ordered to do so by a court of competent jurisdiction or appropriate state agency. Typically, this means the health plan of child's non-custodial parent must provide coverage to the child, even though the child may not meet the definition of a dependent under the plan's eligibility rules. Additionally, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. Participants and beneficiaries may obtain a copy of a group health plan's QMCSO procedures from the Plan Administrator, free of charge.

The following persons are specifically excluded from being considered a dependent and may not be covered under this Plan: other individuals living in your home; an ex-spouse from whom you are legally separated or divorced, an unborn child, any person in active military service (other than as specifically provided for under the Veterans Re-employment Act of 1994, USSERA or any other similar law), anyone residing outside the United States, and your parents, grandparents, or parents-in-law, even if you claim them as dependents on your income tax return.

Events Which Affect Your Plan Benefits

By federal regulations, your coverage elections may not be changed during the Plan year unless you experience a *Change in Family Status*.

Change in Family Status

As a general rule, the following events are among those considered to be a Change in Family Status under this Plan:

- You marry or divorce.
- Your spouse or child dies.
- You gain or lose an eligible dependent.
- The birth or adoption of your child.
- Loss of spouse's or domestic partner's coverage.
- Loss of Medicaid or Children's Health Insurance Program coverage.

Family status change adjustments must be completed within 31 days of the family change; coverage will be deemed effective retroactive to the date of your family change. If you do not make your change within the specified 31-day period, you must wait until the next open enrollment period to do so. Please note that employees or dependents must be given 60 days to request enrollment if they lose Medicaid or Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program or SCHIP) coverage by losing eligibility or becoming eligible for Medicaid or CHIP

assistance with group health plan premiums. **Remember, your requested coverage change must be consistent with your Change in Family Status. For example, if you and your spouse are currently covered and you have a baby, you may change coverage from "You and Spouse" to "Family," but you may not change Plan options.**

If you need to make a change in your coverage during the Plan year due to a Change in Family Status, notify Human Resources.

General Agreement

Covered Person's Agreement

The covered person must pay the copayments applicable to the Plan under which he/she is enrolled. Copayments should be paid to the provider at the time of service.

By choosing the coverage specified in the Plan, paying any required contribution, or accepting benefits in accordance with the Plan, all covered persons, for themselves and their legal representatives, expressly agree to all terms, conditions and provisions of the Plan.

The Plan's Agreement

All rules and decisions of the Plan Administrator and the named fiduciary shall be uniformly and consistently applied to all persons in similar situations. In compliance with federal and state law, the Plan shall not discriminate on the basis of age, sex, color, race, disability, marital status, sexual preference, religious affiliation, or public assistance status in the administration of this Plan.

Legal Relationship of Parties

General Relationship

The Plan Administrator shall have the final discretion to determine Plan benefits. The employer or Plan Administrator shall have the final discretion to determine employee financial participation requirements. The Claims Administrator will administer all health care claims under the Plan and will provide the Plan Administrator with health plan information to assist the Plan Administrator in meeting any applicable ERISA reporting requirements.

The Claims Administrator is an independent contractor retained by the Plan Administrator to provide a health care network, claims processing and services necessary for the operation of the Plan. The Plan Administrator and the Claims Administrator are not joint ventures and neither party is the partner or agent for the other party, except that the Claims Administrator is an agent of the Plan when performing its obligations under the Plan Documents. The Plan Administrator is not an agent of the Claims Administrator under any circumstances.

Neither party shall be obligated to make and shall not make, any payments to employees of the other party for services rendered by them as employees of the other party. Employees of one party shall not be considered as having employee status with the other party or as being entitled to the benefits of any employee of the other party.

The rights of any covered person under the Plan may not be voluntarily or involuntarily assigned or alienated; nor are they subject to the lien of any third party.

Benefit Summary—Union College PPO Plan U

Benefit	In-Network	Out-of-Network
Deductible	None	\$250 Individual \$500 Family
Coinsurance	None	After deductible is met, 20% coinsurance; unless otherwise noted. Plan participant is responsible for the difference between allowed charges and out-of-network charges
Copayments	\$20 copayment—PCP, OB/GYN \$30 copayment—Specialist for the first 10 visits then revert to \$20 copayment	None
Out-of-Pocket Maximums	Employee \$1,250 Employee and Spouse \$2,500 Employee and Child \$2,500 Family \$2,500 There is a separate \$350 individual/\$750 family out of pocket maximum for inpatient and outpatient facility surgery combined.	Employee \$2,500 Employee and Spouse \$5,000 Employee and Child \$5,000 Family \$5,000
Lifetime Maximum	Unlimited	Unlimited
Eligibility	Dependents to Age 26	Dependents to Age 26
Pre-Existing Conditions Exclusion	None	None
Abortion (Elective)	Follows the Surgery benefit	Deductible and 20% coinsurance
Accidental Dental	\$30.00 copay Specialist for first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Acupuncture	Not covered	Deductible and 20% coinsurance
Allergy Immunotherapy Allergy Vials	Covered in full	Deductible and 20% coinsurance
Allergy Testing	\$30.00 copay Specialist for first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Ambulance	Covered in full	Deductible and 20% coinsurance
Anesthesia (Inpatient)	Covered in full	Deductible and 20% coinsurance
Anesthesia (Outpatient/Office)	Covered in full	Deductible and 20% coinsurance
Autologous Blood	Covered in full	Deductible and 20% coinsurance
Cardiac Rehab	Covered in full	Deductible and 20% coinsurance
Childbirth Classes	Not Covered	Not Covered
Chiropractic Care	\$20.00 copay (Unlimited)	50% subject to deductible (20 visits per calendar year)
Contraceptive Devices	Per DME/Supply Benefit based on the item	Per DME/Supply Benefit based on the item
Dental—Routine	Carved out to Delta Dental 1-800-932-0783	Carved out to Delta Dental 1-800-932-0783
Diabetic Services • DME • Supplies • Self Management Education	DME—\$20.00 copay per item Supplies—Lesser of 20% or \$20.00 Education—\$30.00 copay—Specialist for first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Diagnostic Testing	Office—\$20.00 copay All other locations: Covered in full	Deductible and 20% coinsurance
Dialysis & Hemodialysis (Facility & Physician)	OP Facility—\$20.00 copay IP—Covered in full Home—\$20.00 per month OP Physician—\$30.00 copay IP Physician—Covered in full	Deductible and 20% coinsurance

Benefit Summary—Union College PPO Plan U (continued)

Benefit	In-Network	Out-of-Network
DME/Prosthetics/Orthotics/ Disposable Supplies/Medical Supplies <i>(Resource Coordination authorization required for items rented and items over \$500.)</i> Routine Foot Orthotics are not covered	DME: 20% of approved charges Prosthetics/Orthotics/Medical Supplies: Covered in full	DME: 50% subject to deductible Prosthetics/Orthotics/Medical Supplies: Deductible and 20% coinsurance
Emergency Care (Facility) • Covered World Wide	\$100.00 copay; waived if admitted	N/A—All claims processed in-network
Emergency Care (Physician)	Covered in full	N/A—All claims processed in-network
Eye Exams—Routine Once every two years 1 visit per year with a diagnosis of diabetes	\$20.00 copay—PCP \$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Eye Exams—Medical	\$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Family Planning	Paid based on services performed	Paid based on services performed
Genetic Testing	\$30.00 copay	Deductible and 20% coinsurance
Gynecological Exam (Medical)	\$20.00 copay	Deductible and 20% coinsurance
Gynecological Exam (Routine) • Member designated OB/GYN	Covered in full	Deductible and 20% coinsurance
Hearing Aids • PCP referral & UM authorization required • Includes disposable Hearing Aids • Includes replacement parts and repairs • Batteries not covered	20% coinsurance (covered once every three years)	Deductible and 50% coinsurance once every three years
Hearing Exam	\$20.00 copay—PCP \$30.00 copay Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Home Health Care • Based on medical necessity • Pre-authorization required	\$20.00 copay	Deductible and 20% coinsurance
Hospice Care (Inpatient/Outpatient) • 210 day maximum per lifetime combined Inpatient/Outpatient and in-network and out-of-network combined • 5 visits for bereavement counseling	Covered in full	20% of approved charges
Immunizations, Adult and Child • Travel Immunizations If an office visit is billed in conjunction with this service, the office visit copayment will apply.	Covered in full Covered in full	Deductible and 20% coinsurance Covered in full
Infertility Services • Includes In-Vitro	\$20.00 copay—OB/GYN \$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Inpatient Hospital Services • Inpatient Hospital and Outpatient Surgery copay out of pocket maximum combined \$350 individual/\$750 family (separate of the plan benefit out of pocket maximum)	\$150.00 copay	Deductible and 20% coinsurance
Inpatient Physician Visits	Covered in full	Deductible and 20% coinsurance
Lab Services • Preferred Lab Site	Office—\$20.00 copay Covered in full	Deductible and 20% coinsurance
Mammograms Routine Covered once per year Non-Routine	Covered in full Covered in full	Deductible and 20% coinsurance Deductible and 20% coinsurance

Benefit Summary—Union College PPO Plan U (continued)

Benefit	In-Network	Out-of-Network
Maternity (Pre and Postnatal)	\$20.00 copay—initial visit only All other visits covered in full	Deductible and 20% coinsurance
Maternity (Delivery) Including Home Births • Inpatient Hospital and Outpatient Surgery copay out of pocket maximum combined \$350 individual/\$750 family (separate of the plan benefit out of pocket maximum)	\$150.00 copay	Deductible and 20% coinsurance
Mental Health (Inpatient) • Inpatient Hospital and Outpatient Surgery copay out of pocket maximum combined \$350 individual/\$750 family (separate of the plan benefit out of pocket maximum)	Facility—\$150.00 copay Physician—Covered in full	Deductible and 20% coinsurance
<i>Benefits managed by CDPHP Behavioral Health Access Unit 1-888-320-9584</i>		
Mental Health (Outpatient) • Includes Medication Management	\$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
<i>Benefits managed by CDPHP Behavioral Health Access Unit 1-888-320-9584</i>		
Newborn Care (In Hospital)	Covered in full	Deductible and 20% coinsurance
Newborn Hearing Screenings	Covered in full	Deductible and 20% coinsurance
Nutritional Counseling • 2 visits per calendar year • 4 visits per calendar year for newly diagnosed diabetics	\$20.00 copay—PCP \$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Occupational Therapy • 30 visit maximum per condition per year combined in-network and out-of-network	\$20.00 copay	Deductible and 20% coinsurance
Outpatient Chemo/Inhalation/Radiation Therapy (Facility)	Covered in full	Deductible and 20% coinsurance
Outpatient Chemo/Inhalation/Radiation Therapy (Physician)	Office—\$30.00 copay—Specialist for the first 10 visits then revert to \$20 copay All other locations: Covered in full	Deductible and 20% coinsurance
Pap Smears—Routine and Non-Routine	Covered in full	Deductible and 20% coinsurance
Physical—Routine over age 19	Covered in full	Deductible and 20% coinsurance
Physical Therapy • 30 visit maximum per condition per year combined in-network and out-of-network	\$20.00 copay	Deductible and 20% coinsurance
Physician Visits	\$20.00 copay—PCP/OB/GYN \$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Podiatry (Routine)	Not Covered	Not Covered
Prescription Drugs—Retail (up to 30 day supply)	Tier 1 \$10 Copayment Tier 2 \$25 Copayment Tier 3 \$40 Copayment	Tier 1 \$10 Copayment Tier 2 \$25 Copayment Tier 3 \$40 Copayment
90 day supply Mail Order or CVS	Tier 1 \$20 Copayment Tier 2 \$50 Copayment Tier 3 \$80 Copayment	Tier 1 \$20 Copayment Tier 2 \$50 Copayment Tier 3 \$80 Copayment
Private Duty Nursing	20% of approved charges—Prior authorization required	Deductible and 20% coinsurance
Radiology	Office: \$20.00 copay All other locations: Covered in full	Deductible and 20% coinsurance
Rehabilitation Services (Medical)	Covered in full	Deductible and 20% coinsurance
Second Surgical Opinion	\$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance

Benefit Summary—Union College PPO Plan U (continued)

Benefit	In-Network	Out-of-Network
Skilled Nursing Facility • 365 days per year	Covered in full	Deductible and 20% coinsurance
Specialist Visits	\$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
Speech Therapy • 30 visit maximum per condition per calendar year combined in-network and out-of-network	\$20.00 copay	Deductible and 20% coinsurance
Sterilization	Women: Covered in full Men: Follows surgery benefit	Deductible and 20% coinsurance
Substance Abuse—Inpatient • Inpatient Hospital and Outpatient Surgery copay out of pocket maximum combined \$350 individual/\$750 family (separate of the plan benefit out of pocket maximum)	Detox—\$150 copay Rehabilitation—\$150 copay	Deductible and 20% coinsurance
<i>Benefits managed by CDPHP Behavioral Health Access Unit 1-888-320-9584</i>		
Substance Abuse—Outpatient	\$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
<i>Benefits managed by CDPHP Behavioral Health Access Unit 1-888-320-9584</i>		
Surgery (Outpatient Facility)	\$100 copay	Deductible and 20% coinsurance
Surgery (Physician Inpatient/Outpatient)	Covered in full	Deductible and 20% coinsurance
Surgery (Physician—Office)	\$20.00 copay—PCP/OB/GYN \$30.00 copay—Specialist for the first 10 visits then revert to \$20.00 copay	Deductible and 20% coinsurance
TMJ • Diagnosis Only	Based on services rendered	Deductible and 20% coinsurance
Urgent Care Visits	\$25.00 copay	Deductible and 20% coinsurance
Well Child Exam	Covered in full for the following recommended visits: 2 weeks; 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 24 months; and 36 months. Ages 3 to 19: One visit per calendar year. Any other well child visits as recommended by the American Academy of Pediatrics. All other visits \$20 copay	Deductible and 20% coinsurance

NOTE: This benefit summary is intended to be used as a general resource. For clarification, additional information and/or confirmation of benefits, please consult Human Resources or CDPHN.

Health Care Services

Accidental Dental Care

The Plan will pay for any service we cover under this contract in connection with any injury to sound natural teeth if the Plan approves it in advance. Such services must be performed within 12 months of the accident.

Alcohol and Substance Abuse

Detoxification Benefit, the plan provides coverage for Inpatient and Outpatient medical detoxification services for chemical abuse and dependency, including all facility, diagnostic and physicians' charges.

Outpatient Services, the plan provides coverage for the diagnosis and treatment of chemical abuse and dependency. For Family Coverage, family therapy services related to chemical abuse and dependency by a covered dependent. Visits may be used for family counseling even if the covered person in need of treatment is not receiving treatment.

Limitations.

- Services must be provided in: Participating Provider facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services; and, in other states, to those accredited by the J.C.A.H.O. as alcoholism or substance abuse treatment programs.
- Persons whose prime Diagnosis is alcohol abuse or Alcoholism may be treated only in a facility certified to treat such Diagnosis.
- Persons whose prime Diagnosis is substance abuse or substance dependence may be treated only in a Program approved to treat such Diagnosis.
- Care must be as a result of alcohol dependence or substance dependence.
- Treatment of associated health conditions will be Covered under basic Health Care

Inpatient Rehabilitation, the plan provides coverage for Inpatient substance abuse services relating to the diagnosis and treatment of alcoholism, substance abuse and dependency

received at facilities that provide inpatient care and residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASIS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such facilities in accordance with 14 NYCRR parts 817 and 819; and, in other states, to those facilities that are licensed or certified by similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

See the Schedule of Benefits for inpatient and outpatient alcohol and substance abuse benefits. Benefits must be coordinated through the CDPHP Behavioral Health Access Unit 1-888-320-9584.

Ambulance Benefits

The Plan will pay for medically necessary ambulance service according to the Benefit Schedule. Ambulance benefits include transportation to and from a hospital, between hospitals, and between a hospital and a skilled nursing facility. Coverage includes transportation by air ambulance when determined to be medically necessary.

Autism Mandate

The Plan has adopted the New York State Autism Mandate effective January 1, 2014. Applied Behavioral Analysis (ABA) services are covered under the behavioral health benefit and are subject to yearly maximum hourly visit limitation. Prior authorization by CDPHN's Medical Director or his/her designee is required for some services.

Breast Reconstruction Surgery

Coverage for breast reconstruction surgery after a mastectomy for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined by the attending physician and the patient to be appropriate.

Diabetic Durable Medical Equipment

Prior authorization by CDPHN's Medical Director or his/her designee is required for Medically Necessary Diabetic Durable Medical Equipment and related supplies costing \$500 or more. This Covered equipment includes, but is not limited to, items such as: injection aids, insulin pumps, insulin-pump supplies and accessories, insulin infusion devices, data management systems, blood glucose monitors (including non-invasive, subcutaneous or implantable monitors) and blood glucose monitors for the legally blind.

Durable Medical Equipment

Durable medical equipment is eligible for in-network coverage if it is prescribed by a network physician and authorized by the Plan as necessary for the proper care and treatment of a condition. If it is not prescribed by a network physician, it is covered out-of-network. Coverage is provided for standard equipment and only when it is medically necessary. "Take-home" items from a hospital, resulting from an inpatient stay or outpatient treatment, are not eligible for coverage under the Plan.

The option of whether to rent or purchase durable equipment is at the sole discretion of the Plan.

The items the Plan *will pay* for include, but are not limited to, oxygen and oxygen equipment, contact lenses and eyeglasses for medical purposes, a non-motor driven wheelchair, hospital

bed, braces or crutches. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Medical supplies and disposable medical supplies and medical supplies and disposable supplies for use with covered devices or equipment.

Items the Plan *will not* pay for include, but are not limited to, deluxe equipment (such as a motor-driven wheelchair) when standard equipment is available and medically adequate, items not medical in nature, comfort and convenience items, exercise and hygiene equipment, sauna bath, air conditioners, humidifiers and dehumidifiers, experimental or research equipment, and electronic communication devices. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear.

CDPHN Resource Coordination prior authorization is required for rental items and items costing \$500 or more.

Emergency Care

A medical emergency is defined as 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:

1. 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;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

All emergency care is subject to review for medical necessity. Inappropriate use of the emergency room will not be paid for by the Union College PPO Plan U.

Emergency Care Within the Service Area. You are entitled to medically appropriate emergency care at an emergency room of a hospital or an urgent care facility. You will be responsible for a copayment for each emergency room visit. Check the Schedule of Benefits to determine your copayment. When hospitalization immediately follows as a result of the emergency medical condition, the emergency room copayment will be waived.

Emergency Care Outside the Service Area. You are entitled to medically appropriate emergency care in a hospital or from a physician.

Non-Emergency Use of the Emergency Room

The Plan urges employees and their covered dependents to contact personal physicians for all non-emergency care. The Plan discourages the use of the hospital emergency room for non-emergency situations that could be handled with greater knowledge of the relevant medical condition and at less cost by a personal physician. The Plan reserves the right to deny any emergency room claim which it considers inappropriate.

Home Health Care

You are eligible for the following home care services by a private or public home care agency subject to any applicable copayments, coinsurance and deductibles as well as limits as noted in the Schedule of Benefits:

We will pay for the following as long as the Plan determines it is medically necessary, and not custodial care as defined in the section entitled "Skilled Nursing Facility Care."

- A. Home nursing care by, or under the supervision of a registered nurse; when determined to be medically necessary.

- B. Part time intermittent health aide services. Such services must consist primarily of caring for the patient; and not custodial care as defined in the section entitled “Skilled Nursing Facility Care.”
- C. Short term physical and/or speech therapy for acute conditions if provided by home health agency personnel; or other qualified providers if not available through home health agency personnel.
- D. Medical supplies, drugs and medications prescribed by a physician and laboratory services, to the same extent as would be covered if the person were hospitalized.
- E. Medical Social Services if provided by a participating provider or Home Health Agency personnel.

Hospice Care

Up to 210 days of hospice care is available in a hospice or hospital; and home care and out-patient services provided by the hospice, including drugs and medical supplies, are covered, as long as:

1. The covered individual has been certified by his/her primary attending physician as having a life expectancy of six months or less; and
2. The hospice care is provided by a hospice organization certified pursuant to state law.

Five visits for bereavement counseling for your family either before or after the death of the covered family member are also covered.

Hospice benefits are covered in full in-network and subject to coinsurance and deductible out-of-network—see Schedule of Benefits.

Hospital Services

All medically necessary inpatient and outpatient hospital services, when arranged by your primary care physician, are covered as in-network benefits by this Plan subject to any limitations, exclusions and copayments described in this booklet. All medically necessary inpatient and outpatient services, not arranged by your primary care physician are covered as out-of-network benefits subject to allowable charges, coinsurance and deductibles. Medically necessary services include:

- Inpatient physician services.
- Intensive care unit and coronary care unit charges.
- Maternity care coverage, including parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments, for the member and the newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and at least 96 hours following a caesarean section. The member will have the option to be discharged earlier than the 48 or 96 hours. In such case, one home health care visit, which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of caesarean section), shall be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother’s request, whichever is later. Any such home health care visit shall not be subject to deductibles, coinsurance or copayments.
- Miscellaneous hospital services and supplies required for treatment during a hospital confinement.
- Outpatient hospital services, including pre-admission testing, and outpatient surgery.
- Rehabilitation hospital admissions: (e.g. following a stroke) not related to substance abuse will be covered for acute conditions subject to clinical improvement over a relatively short term.

- Room and board, not to exceed the cost of a semi-private room. Private room expenses will be covered only if a private room is medically necessary.
- Well-baby nursery and physician expenses during the initial hospital confinement of a newborn, if the newborn is properly enrolled in the Plan.

Human Organ and Bone Marrow Transplant Procedures

Transplant procedures will be evaluated on a case-by-case basis, and will be covered only if medically necessary in light of the covered person’s overall medical condition. Approval by the Medical Director is required to determine if services are eligible for coverage. Coverage for transplants will be limited to one per lifetime of each organ or bone marrow.

Donor costs are not covered under the Plan.

Infertility

Services and services for infertility are covered under the Union College PPO Plan U. The patient must be an active plan participant at the time services are rendered and be at least 21 years of age but no more than 44 years old to be covered.

This plan will provide benefits for medically necessary diagnostic testing and treatment, including diagnostic tests and operative procedures to identify and correct abnormalities for the sole purpose of inducing pregnancy. The plan will also provide services associated with treatment to correct the condition of infertility.

Artificial insemination and in-vitro fertilization to induce pregnancy are covered by the plan. The GIFT program is not covered.

Laboratory and X-Ray Services

The Plan covers laboratory and X-ray services when ordered by your primary care physician and provided by a participating provider. If you do not obtain a referral or use a network facility, coverage will be out-of-network and subject to deductible and coinsurance.

Maternity Benefits

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

Mental Health Care

Inpatient Services—The plan provides coverage for inpatient mental health care services relating to the mental, nervous and emotional disorders comparable to other similar hospital, medical and surgical coverage provided under the Plan. Coverage for inpatient services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A part of a hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;

- A comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating by the New York State Commissioner of Mental Health;
- And in other states, to similarly licensed or certified facilities.

The Plan also provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment.

Outpatient Services—The Plan participant must contact CDPHN's designated managed behavioral health care organization prior to receiving Covered Health Services from a licensed mental health counselor, a psychiatric nurse practitioner, a licensed psychologist or psychiatrist, a licensed clinical social worker or professional corporation or university faculty practice corporation.

Service for outpatient care are covered whether individual or group therapy for diagnosis and treatment of Mental Health Conditions. Outpatient services include care provided in a facility issued an operating certificate by the commissioner of mental health or in a facility operated by the office of mental health, or office-based Mental Health Care.

Partial Hospitalization treatment is covered with two partial hospitalization days for mental health care equaling one covered inpatient hospitalization day of mental health care.

See the Schedule of Benefits for inpatient and outpatient mental health benefits.

CDPHP Behavioral Health Access Unit 1-888-320-9584

Office Visits

The Plan will provide In-Network benefits for office visits to your Participating Practitioner (physician or specialist)—including clinic visits billed by a hospital for treatment of illness, disease and injury. The copayment shall cover all services performed in the office during the office visit, including any and all x-ray or laboratory tests performed, even though they may be sent to an outside facility for processing/evaluation.

The Plan provides Out-of-Network benefits for office visits and services of a non-Participating Practitioner (physician or specialist).

Orthotics

The Plan provides benefits for orthotics. Foot orthotics must be Medically Necessary to qualify for Coverage. Routine foot orthotics are excluded from Coverage. Routine podiatry is excluded from Coverage. CDPHN Resource Coordination prior authorization is required for items costing \$500 or more.

Physical, Occupational and Speech Therapy—Outpatient

Physical, occupational, speech and other short term rehabilitative services will be covered for up to a 30 visit maximum per occurrence per calendar year with the copayment and or coinsurance listed in the Schedule of Benefits if the following two conditions are met:

1. Such care is sought within one year of the trauma, illness or surgery which necessitated this treatment, and,

2. Such care is expected, in the judgment of the Plan, to result in significant improvement of your condition.

Benefit limitations are a combination of in- and out-of-network benefits.

Prescription Drug Coverage

CVS Caremark Pharmacies

When you use a CVS Caremark Pharmacy there are no claim forms to file. The Plan covers prescription drug expenses for a short-term supply of drugs (i.e. up to 31 days). To purchase prescription drugs through a participating CVS Caremark pharmacy: show the pharmacist your identification card, and pay the \$10 copayment for Tier 1 drugs; \$25 copayment for Tier 2 drugs or; \$40 copayment for Tier 3 drugs.

Maintenance Medications

Maintenance medications must be obtained through the Plan's Pharmacy Mail Service or at a CVS pharmacy retail location. The plan allows three 30-day fills of long term medications at any pharmacy in our network. After that, the plan will only cover maintenance medications in 90 day supplies filled either through mail service or at a CVS pharmacy.

Maintenance drugs are defined to be any drug, taken regularly, used to treat or prevent a chronic health condition such as, but not limited to, high blood pressure, diabetes and asthma. Diabetic supplies as mandated by New York State and subject to appropriate medical copayment or coinsurance are also covered.

Maintenance Choice is a program offered by CVS Caremark which provides 90 day prescriptions filled at CVS locations with mail order pricing. This allows the plan participant to establish/maintain the face to face relationship with the pharmacist.

Specialty Pharmacy

Specialty pharmacy agents must be obtained at CDPHN's participating specialty vendor(s.) Up to a 30-day supply is available. Specialty Drugs may be administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical or inhalation. CDPHN designates drugs as specialty through evaluation of the following characteristics: frequency of dosage adjustments, frequency of severity of adverse effects and side-effects, requirements for storage, handling and/or administration, therapeutic range, frequency of required laboratory or diagnostic testing for monitoring safety or effectiveness, increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home healthcare therapy, requirements for significant on-going one-to-one patient support and education to maintain patient compliance and to ensure the proper storage/handling/administration of the drug, severity of compliance risk, need for work-life adjustments by patients or caregivers to adhere or successfully implement the therapy and limited distribution of the drug.

Prior Authorization

Your physician must notify CDPHN's Resource Coordination department when he or she recommends hospitalization or services for, but not limited to, skilled nursing facility care, home health care, inpatient rehabilitation unit or facility services, prosthetic devices, some identified medications, durable medical equipment, home dialysis and hospice care. Generally, your physician requests prior authorization from CDPHN, however, it is your responsibility to make sure that prior authorization is received before receiving a service. After review, CDPHN will notify you, your 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 member to have the proposed services, CDPHN will contact you and the physician with the determination.

Prosthetic Appliances

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

Items the Plan *will not* pay for also include, but are not limited to: any appliance or device that could be used by any other member of your family or person with your condition, arch supports, corrective shoes, experimental or research appliances or devices, electronic communication devices, and dental prosthetics, except in connection with accidental injury to sound natural teeth. CDPHN Resource Coordination prior authorization is required for items costing \$500 or more.

Skilled Nursing Facility Care

The following skilled nursing benefits are covered in full in-network and subject to coinsurance and deductible out-of-network for 365 days per year.

You are eligible for services in a skilled nursing facility only if your admission to the skilled nursing facility is authorized by the Plan. You must also meet the following conditions:

- A. Your admission must be for the continuing treatment of the condition for which you were hospitalized; and
- B. You must require skilled nursing or skilled rehabilitation services which:
 1. Are required on a daily basis; and
 2. Can be provided only on an in-patient basis.
 3. Skilled Nursing Facility—A skilled nursing facility is a licensed facility which is approved for participation as a skilled nursing facility under Medicare. Also included are those that are certified as a skilled nursing facility by the Joint Commission on the Accreditation of Healthcare Organizations.
4. Custodial Care is not provided—The Plan will not provide benefits for any day in a skilled nursing facility which is determined to be primarily for custodial care. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include:
 - A. Assistance in meeting activities of daily living such as feeding, dressing, and personal hygiene;
 - B. Administration of oral medications, routine changing of dressing or preparation of special diets;
 - C. Assistance in walking or getting out of bed; or
 - D. Child care necessitated by your incapacity.

Temporomandibular Joint Syndrome (TMJ)

The Plan will cover any diagnostic studies or treatment in connection with temporomandibular joint syndrome (TMJ) or disease. This includes, but is not limited to, diagnosis or treatment for clicking or grinding of the temporomandibular joint; soreness of the jaw muscles; stiffness of the jaw; spasm of the muscles or pain involved with chewing; or limitations or displacement of the temporomandibular joint; difficulty in opening the mouth, in connection with TMJ syndrome or disease.

Benefits are provided for treatment of temporomandibular joint disorders which demonstrate intracapsular pathology caused by systemic illness (i.e. rheumatoid arthritis) or are due

to a documented history of trauma. Benefits are Not provided for the treatment of dental related temporomandibular joint dysfunction.

Covered services will be subject to any applicable copayments, coinsurance and deductibles as described in the Schedule of Benefits.

Wigs

The plan provides coverage for wigs to a maximum of \$400.00, twice per lifetime. CDPHN Resource Coordination prior authorization is required.

Exclusions

The following health services are specifically excluded from coverage under this Plan:

- Any service provided that exceeds the stop loss level unless the participant agrees to sign CDPHN's Medical Authorization Release Form.
- Any service that is not included in the Plan, even though provided or referred by a physician.
- Any service that is not medically necessary, even if listed as a covered service in the benefit description.
- Any service that is not required in accordance with accepted standards of medical, surgical, or psychiatric practice, even though provided or referred by a network physician.
- Any service required only for the convenience of the covered person or the covered person's physician.
- Any services that the Plan has no legal obligation to cover.
- Free clinics.
- Government programs.
- Any charge made solely because the covered person has the benefit covered by the Plan.
- All medical and hospital care associated with conditions for which written preauthorization by the Medical Director is required and was not received.
- Expenses for medical and/or hospital services incurred prior to coverage under the Plan or services provided after the Plan coverage or eligibility terminates.
- Braces and artificial limbs (except as described in the Prosthetic Appliances section).
- Total parenteral nutrition (TPN) except when the need for TPN results from a condition diagnosed after the date of Plan enrollment preauthorized based on established criteria.
- Post-mortem testing.
- Charges for missed appointments in provider's offices and/or charges incurred when scheduled services are canceled by the covered person.
- Services that covered persons are entitled to as a result of class action or special group settlements, for example, Agent Orange treatment programs and asbestosis indemnification funds. If specific treatment facilities are not stipulated by the responsible agency or group, the Plan will provide the services contingent on either coordination of benefits or the subrogation rights explained in Your Rights and Responsibilities Section on Coordination of Benefits and Subrogation.
- 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.

- Blood, blood plasma, or products derived in whole or in part from blood or blood plasma, and special handling fees.
- Gene manipulation therapy.
- Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies.
- Services rendered by a provider with the same legal residence as the covered person, or a member of the covered person's family, including spouse, brother, sister, parent or child.
- Custodial, maintenance, convalescent and/or domiciliary care, respite care (except as specifically provided for in Hospice Care Section of this chapter), rest cures, whether furnished in the home or in an institution, including a nursing home or similar facility.
- Travel or transportation expenses (except ambulance service as specifically provided under the Plan) even though prescribed by a physician or to reach a network or designated Plan facility.
- Academic, educational or cognitive testing and related therapy.
- Career, marriage, educational or financial counseling and self-help therapies.
- Services for all complications resulting from any non-covered service.
- Hospitalization for non-covered services and all related costs.
- Procedures intended to result in pregnancy including, but not limited to, any form of surrogacy, except as covered under Infertility and Family Planning.
- Medical and/or psychiatric evaluation, therapy, service, supply or hospitalization while in the custody of or incarcerated by any federal, state or municipal agency or body.
- Routine support devices for the feet and corrective shoes.
- Physical, psychiatric and psychological exams, or immunizations/inoculations required by third parties. These include, but are not limited to, employment, insurance, camp and court ordered exams.
- Radial keratotomy or other refractive surgery.
- Routine podiatry.
- Services as a result of any acts of war, declared or undeclared, or any type of military conflict.
- Services covered by government programs which should be treated in a public facility as required by state or local law.
- Services for injury, illness, mental illness or chemical dependency incurred or contracted, to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony or which occurs while the Covered Person is engaged in an illegal act or occupation.
- Services that the Claims Administrator determines are not medically necessary for the diagnosis or treatment of an illness, injury, mental illness or chemical dependency.
- Unnecessary hospital stays and all costs related to a hospitalization when a covered person remains in the hospital after a physician has determined that hospitalization is no longer medically necessary.
- Dental Services, The Plan will not provide benefits for treatment for cavities and extractions, care of the gums or bones supporting the teeth, treatment of periodontal abscess, orthodontia, false teeth, orthognathic treatment and surgery, or any other dental services you may receive. The Plan will, however, provide benefits for Accident Related Dental Services and for treatment needed due to congenital disease or anomaly.

- Reversal of Sterilization
- Medical equipment, supplies, appliances, cosmetics, and shoe orthotics that are not medically necessary, computer assisted communication devices or electronic communication devices that are not implanted into the body, convenience items, personal comfort items, and athletic equipment even though prescribed by a physician.

Experimental, Investigational, Unproven, Unusual, or Not Customary Treatments, Procedures, Devices and/or Drugs Not Covered

A treatment, procedure, device and/or drug shall be deemed excluded as experimental, investigational, unproven, unusual, or not customary if:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use, or
- It is the subject of a current investigational new drug or new device application on file with the FDA, or
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial, or
- It is being provided pursuant to a written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness or effectiveness in comparison to conventional alternatives, or it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS), or
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings, or
- If the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives, or
- It is not a covered benefit under Medicare as determined by the Centers for Medicare & Medicaid Services (CMS) of HHS, or
- It is experimental, investigational, unproven, unusual or not customary or is not a generally acceptable medical practice in the predominant opinion of independent experts, or
- A majority of a representative sample of not less than three health insurance or benefit providers or administrators consider the request treatment, procedure, device or drugs to be experimental, investigational, unproven, unusual or not customary based upon criteria and standards regularly applied by the industry, or
- It is not experimental or investigational in itself pursuant to the above, and would not be medically necessary, but for being provided in conjunction with the provision of a treatment, procedure, device or drug which is experimental, investigational, unproven, unusual or not customary.
- Weight Loss Clinics

Determinations under this Section will be based on the following:

- The covered person's medical records,
- The protocol(s) pursuant to which the treatment is to be delivered,
- Any informed consent documents the covered person is required to read and/or execute, as a condition of receiving the treatment,

- The published authoritative medical or scientific literature regarding the procedure at issue as applied to the covered person's medical condition,
- Regulations, bulletins, letter rulings or other official actions and publications issued by the FDA, HHS, CMS, the National Institutes for Health (NIH), the National Cancer Institute (NCI) or other applicable regulatory agencies,
- The opinions of independent experts,
- Materials prepared by, for or on behalf of other health insurance or benefit providers and administrators concerning the requested treatment, procedure, device or drug, and/or
- Recognized technology assessments or evaluations by private or federal entities (e.g. Blue Cross & Blue Shield Association, American Medical Association, Office of Technology Assessment),
- Other materials that, in the exercise of the Plan Administrator's discretion, are relevant.

No treatment, procedure, device and/or drug excluded by this section on the inception date of the Plan shall be covered because it subsequently ceases to meet the criteria of this section during the remaining contract year, unless the Plan issues a written amendment expressly making it a covered benefit.

Medications that are experimental, investigative, or used in ways not approved by the Food and Drug Administration (FDA) are not covered.

Medications included in these categories are those prescribed for: Use in dosage forms not commercially available, Use by routes of administration not approved by the FDA, Non-FDA approved indications, Naturopathic services and Megavitamin therapy.

General Limits

Cumulative Benefits

Any service provided a participant or dependent during a contract year is limited cumulatively to these benefits covered in the Plan. The following changes in a covered person's status may not increase any restriction or limitation on the number of services or benefits a covered person can receive in a contract year:

- From participant to beneficiary.
- From beneficiary to participant.
- From group coverage to continuation coverage, or individual plan coverage.
- From employer group contract to another employer group contract.

Circumstances Beyond the Plan Administrator's Control

If, due to circumstances not reasonably within the control of the Plan or Claims Administrator, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of a hospital or physician network, or similar causes, the rendition or provision of benefits covered hereunder is delayed or rendered impractical, hospitals and physicians associated with the Plan will make a good faith effort to provide benefits covered hereunder, but neither the Plan nor the Claims Administrator, hospitals, nor any physician associated with the Plan will have any other liability or obligation on account of such delay or such failure to provide covered benefits.

Major Disaster or Epidemic

If a major disaster or epidemic occurs, physicians and hospitals will provide medical and hospital services and arrange extended care services and home health services as far as is practical according to their best judgment. These services will be within

the limitation of available facilities and personnel, but neither the network hospitals, nor any physician associated with the Plan, has any liability or obligation for delay or failure to provide or arrange for any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.

Termination of Coverage

Your coverage will terminate on the earliest of the following dates:

1. The date you cease to be eligible for coverage under the Union College PPO Plan U;
2. The date on which you discontinue any required contribution (coverage terminates on the last day of the contribution period);
3. The date the Union College PPO Plan U is terminated;
4. The last day of the month in which your active employment ends.

If your active service ends because of injury, sickness, temporary layoff or leave of absence or retirement, part or all of your coverage may be continued.

Additional Benefit Information

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Continuation of Coverage

Availability. To the extent required by Federal law, continuation coverage will be made available under the Plan. Continuation coverage provides a means to continue your Plan group coverage at your own expense for a limited time, even if you are no longer eligible for coverage paid by the employer.

Continuation coverage is not automatic. The participant or beneficiary must be eligible, must elect to take the coverage, must complete an enrollment application, and must make the necessary premium payments. This coverage is based on certain qualifying events.

Continuation of Coverage Rules. This section summarizes the various provisions of COBRA and should not be regarded as a complete discussion of the applicable provisions.

For dissolution of marriage, legal separation, or changes in dependent status, the covered person must notify the Plan Administrator within 60 days of the event.

Length of Continuation Coverage and Premium

NOTE: For the purpose of this section "Qualified Beneficiary" shall include both the participant and beneficiary.

If a qualifying event occurs, the Plan Administrator will supply qualified beneficiaries with individual notice and a form to elect continuation coverage. Qualified beneficiaries must make their election within 60 days of the later of the following:

- The date of termination of coverage under the Plan.
- The date the qualified beneficiary receives notice of the right to continuation of coverage.

A qualified beneficiary must pay the current premium for continuation coverage no later than 45 days after the beneficiary's election to continue coverage.

The premium may be up to 102 percent of the composite rate based upon such factors as age, sex, health status and experience of the covered persons. There is one exception: For a disabled beneficiary, the premium may be increased from 102 percent to 150 percent for months 19–29 of continuation coverage.

Coordination of Benefits and Subrogation

Coordination of Benefits

Order of Benefit Determination Rules—General. When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan unless:

- The other Plan has rules coordinating its benefits with those of this Plan, and both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan; or
- The other Plan is a governmental Plan or coverage required or provided by law, and this Plan is required by law or regulation to be the Primary Plan. A basis for a claim under a governmental Plan can exist when a covered person is covered or eligible for coverage under the Plan, whether or not the covered person applies for or receives benefits thereunder. The conditions shown are current examples (subject to change) of some of the areas in which this Plan is required to be the primary plan.
- The covered person is covered under the Civilian Health and Medical Program of the Uniformed Services (Tri-Care).
- The covered person is covered under Medicaid.
- The covered person is actively at work and is age 65 or older, and is enrolled as a subscriber or as a dependent of a subscriber (of any age) in the group coverage of a subscribing group with 20 or more employees.

Coordination of Benefits—General

The benefits available to covered persons under any other Plan will be coordinated pursuant to the provisions of this section to avoid duplicate payment to covered persons for the same or similar benefits or services.

Applicability. This Coordination of Benefits ("COB") provision applies to the Plan when a participant or the participant's beneficiary has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

- Will not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another Plan; but
- May be reduced when, under the order of benefits determine rules, another Plan determines its benefits first.

If a covered person is eligible for services or benefits under two or more plans, the coverage under those plans will be coordinated so that up to, but no more than, the total allowable expenses during the claim determination period will be paid for, or provided by, all the plans, less any copayments, coinsurance and deductibles. The Plan, as a secondary payer, may reduce its benefits so that the total benefits paid or provided by the plans during a claim determination period are not more than the total allowable expenses.

Definitions

The following definitions will apply to this section:

"Plan" any of the following which provide benefits, indemnification or services for, or because of, medical or dental care or treatment covered by this Plan

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice

or individual practice coverage. It also includes coverage other than school accident-type coverage.

- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Grants to States for Medical Assistance Programs, Title XIX of the United States Social Security Act, as amended from time to time).
- Individual automobile "no-fault" or traditional "fault" type contracts.
- Hospital indemnity benefits in excess of \$100 per day.

Each contract or other arrangement for coverage under any bulleted item above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"Primary Plan/Secondary Plan" The order of benefit determination rules state whether this Plan is a primary plan or a secondary plan as to another plan covering the person.

When this Plan is a primary plan, its benefits are determined before those of the other Plan and without considering the other plan's benefits.

When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the individual, this Plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made.

The difference between the cost of a private hospital room and cost of semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered individual does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provision are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

Rule A—Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, insured, participant or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the individual as a dependent.

Rule B—Dependent Child/Parents not Separated or Divorced. Except as stated in Rule C below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

- The benefit of the Plan of the parent whose birthday falls earlier in a year are determined before those of

the Plan of the parent whose birthday falls later in the year; but

- If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in the first bulleted item immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule of the other Plan will determine the order of benefits.

Rule C—Dependent Child/Parents Separated or Divorced.

If two or more plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with the custody of the child; and
- Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any claim determination period during which any benefits are actually paid or provided before the entity has that actual knowledge.

Rule D—Joint Custody.

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Rule B.

Rule E—Active/Inactive Employee.

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, then Rule E is ignored.

Rule F—Longer/Shorter Length of Coverage.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, insured, member, covered person, participant, beneficiary or subscriber longer are determined before those of the plan which covered that individual for the shorter term.

**Effect on the Benefits of This Plan
When This Section Applies**

This Subsection applies when, in accordance with the above Subsection, Order of Benefit Determination Rules, this Plan is a secondary plan to one or more plans. In that event, the benefits of this Plan may be reduced under this Section. Such other plan or plans are referred to as “the other plans” in the section immediately below.

Reduction in This Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision; and
- The benefits that would be payable for the allowable expenses under the other plans, in the absence of provision

with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

Only the amount of benefit actually paid by this Plan may be charged against any applicable benefit limit under this Plan.

**Right to Receive and Release
Needed Information**

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. The Plan need not tell, or get the consent of, or provide notice to, any individual to do this. Each individual claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

**Coordination of Benefits
When Medicare is Primary**

When the Physician Accepts Assignment

When Medicare is primary and the provider has “accepted assignment” the Plan will calculate the amount of the covered expense using the Medicare approved amount.

In the following examples, the Physician accepts assignment so both the Plan and Medicare will base their calculations on the Medicare approved amount of \$125.00.

Example (a)—Payment for an office visit.

Plan Benefits: \$20 copay then 100% coverage

Physician Charges: \$150

Medicare Allows: \$125. Pays 80% of the allowed amount or \$100.00.

Plan pays \$5. The Plan calculates 100% of the Medicare Allowed Charge (\$125) and determines that to be the Plan benefit. In this instance, \$20 copayment + \$100 Medicare = \$120. Physician is required to accept this as full payment.

You pay: \$20 copayment.

**When the Physician Does Not
Accept Assignment**

If the provider has not agreed to limit charges for services and supplies to the amount approved by Medicare, 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 the 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 the amount payable under the Plan benefits. *The Plan pays only the difference between Medicare benefits and the Plan benefits for the same expenses.*

In the following examples, the Physician does NOT accept assignment so; the Plan will base its calculations on the reasonable charges (\$90), as they are less than the amount the

Provider charged (\$150). Medicare will base its calculations on the Medicare allowed amount (\$125).

Example (b)—Payment for an office visit.

Plan Benefits: \$20 copay then 100% coverage

Physician Charges: \$150

Medicare Allows: \$125. Pays 80% of the allowed amount or \$100.00.

Plan pays \$0. The Plan calculates 100% of the Medicare Allowed Charge (\$125) and determines that to be the Plan benefit. In this instance, \$20 copayment + \$100 Medicare = \$120. Physician is not required to accept this as full payment and may bill you the additional amount.

You pay: \$20 copayment + \$30 balance.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than it should have paid under the COB provision, it may recover the excess from one or more of:

- The individuals it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

Motor Vehicle No-Fault Insurance

If a covered person owns and operates a motor vehicle on the public highways, the covered person is required to have no-fault insurance, which covers certain medical and rehabilitation expenses incurred if a covered person or others are injured in an automobile accident.

The Plan is authorized by law to coordinate its coverage with a covered person’s no-fault insurance. This means that if a covered person is injured in an automobile accident, the automobile no-fault insurance will pay first, and the Plan will provide coverage only if the amount of no-fault coverage is insufficient to pay for all of the medical expenses.

Coverage under the Plan may include the amount of the deductible under the no-fault coverage.

If a covered person is injured while riding in or operating a vehicle owned by the covered person, and the vehicle is not covered by no-fault insurance as required by law, benefits under the Plan will not be available to the covered person, up to the minimum amount of no-fault insurance coverage required by law.

This denial of benefits will not apply to any covered person injured in an automobile accident if the injured covered person is a non-owner operator, passenger, or pedestrian and the vehicle is not covered by no-fault insurance.

If the no-fault insurance policy provides coverage in excess of the minimum required by law, the Plan will coordinate benefits with the amount of the coverage provided.

If there is an automobile policy in effect, and the covered person waives or fails to assert his/her rights to the no-fault benefits, the Plan will not pay the benefits that would have been available under the no-fault policy.

The Plan reserves the right to require proof that the automobile policy has paid all benefits required by law before the Plan pays any benefits.

After benefits under the no-fault policy have been exhausted, coverage under the terms of the Plan will be available only if the insured obtains all medical care for covered benefits in compliance with the Plan.

Workers’ Compensation

The Plan will not provide benefit services or supplies required as a result of a work-related illness or injury. This applies to illness or injury resulting from occupational accidents or sickness covered under any of the following:

- Occupational disease laws.
- Employer’s liability.
- Federal, State or municipal law.
- The Workers’ Compensation Act.

To recover benefits for a work-related illness or injury, the covered person must pursue his/her rights under the Workers’ Compensation Act or any of the above provisions that may apply to the illness or injury. This includes filing an appeal with the Industrial Commission, if necessary.

When a legitimate dispute exists as to whether an injury or illness is work-related, the Plan will provide benefits during the appeal process if the covered person signs an agreement to reimburse the Plan for 100% of the benefits provided.

The Plan will not provide benefit services for a work-related illness or injury even under the following circumstances:

- The covered person fails to file a claim within the filing period allowed by law.
- The covered person obtains care that is not authorized by Workers’ Compensation. The covered person fails to comply with any other provisions of the law.
- The covered person has a choice of providers, which includes a network provider, elects to use a non-network provider and the claim is subsequently denied by Workers’ Compensation.
- Benefits will not be denied to an employee whose employer has not complied with the laws and regulations governing Workers’ Compensation Insurance, provided that such employee has sought and received services under the provisions of the Plan.

Subrogation

The Plan will not cover any services or supplies for which a third party is liable or has agreed to make payment. In such cases, all of the following will apply:

- The covered person shall promptly notify the Plan of any claim against or recovery from the third parties.
- The covered person shall cooperate in every necessary way to help the Plan enforce its right to pursue and collect from the third party.
- The covered person shall hold recovery proceeds in trust for the Plan.
- The Plan shall be subrogated and will succeed to any covered person’s right of recovery from a third party for the amount of actual expenses paid by the Plan, as well as future medical expenses not yet incurred, which are related directly to the injury or illness and are the responsibility of a third party.

The covered person will reimburse the Plan as explained below:

When the covered person has received payment from the third party, as a result of judgment, settlement, or otherwise, the covered person will first reimburse the Plan for the amount of actual expenses paid. An agreement pertaining to a fair present value payment or trust account to cover future medical expenses

will be established by the Plan and the covered person in the event of a lump sum award or settlement of a claim for future medical expenses. In the absence of such an agreement, the Plan will exclude coverage for future medical expenses related to the injury or illness up to the amount of the award.

The right of reimbursement of the Plan comes first even if a covered person is not paid for all of his claim for damages against the other person or organization or if the payment he receives is for, or is described as for, his damages (such as for personal injuries) for other health care expenses or if the covered person recovering money is a minor.

The Plan will be reimbursed subject to reduction equal to the Plan's pro rata share of the attorneys' fees and costs incurred by the covered person in obtaining the recovery. In no event will the Plan pay more than 33 percent of the Plan's recovery in attorney's fees.

Should a covered person refuse or fail, for any reason, to pursue his rights, then the Plan will have the right to initiate an action as subrogee in the covered person's name or in the Plan's name, at the Plan's election, to recover eligible charges provided under the Plan, and the covered person will cooperate fully in the pursuit of any such action.

The covered person will, on request, execute and deliver whatever documents or whatever else the Plan determines is necessary to carry out the provisions of this Subsection.

The provisions of this Section are binding on all covered persons by virtue of Subsection Covered Person's Agreement. However, the Plan may condition the payment of benefits on the covered person's (or his/her personal representative's) express written acceptance of the provisions of this Subsection.

Records Confidentiality

Privileged information from medical records of covered persons, including mental health records, and information about the physician-patient relationship will be confidential. The Plan will not voluntarily disclose this information without prior written consent of the covered person except for use of the medical records necessary to administer the Plan; use of the medical records for medical research and education; bona fide peer review during records review or utilization review programs established to promote quality medical care; provision of statistical utilization data to the employer; use of the medical records for a bona fide medical emergency; and any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.

Access to Records

Either the Plan Administrator or the Claims Administrator will keep records about covered persons with details about their coverage. Upon request, the Plan Administrator will submit to the Claims Administrator or give the Claims Administrator reasonable access to, information and records about covered persons that may be required to administer claims for the Plan.

Wrong Information/Erroneous Information

The Plan is not liable for fulfilling any obligation based on information it has not yet received in a form satisfactory to the Claims Administrator. Erroneous information can be corrected, unless the Plan has acted on the erroneous information to its disadvantage.

Litigation

Prior to bringing an action in court against the Plan, or its agents, a claimant must first exhaust his/her administrative

remedies under the Plan Documents. If no appeal is filed with the Claims Administrator and instead the covered person involves the Plan or its agents in litigation in defense of which the Plan incurs legal expense, the Plan will take action to recover all of its legal expenses.

No legal action for any claim for Plan benefits can be filed more than one year after the submission of a claim for Plan benefits, nor shall any such action be commenced prior to the exhaustion of the appeal process set forth in this Section.

Amendment/Termination of Plan

The Plan cannot be changed unless the change is approved by the Plan Administrator, and shown by an endorsement on it, or by amendment to it signed by the Plan Administrator and by an executive of the Claims Administrator.

The Plan may be amended, changed or terminated as stated in the Subsection above, without the consent or agreement of its covered persons or any person having a beneficial interest in it. Any change or amendment will not affect the outcome of any benefit claim made before the date of the change.

The employer adopting the Plan does not guarantee or represent that the Plan or benefit description will continue indefinitely with respect to any class of participants. Although the employer intends the Plan to be permanent, it reserves the right to amend or terminate the Plan, with regard to its employees and/or retirees at any time in the future. Nothing in the Plan shall be constructed to extend benefits beyond the date upon which they would otherwise end in accordance with the provisions of the Plan or any benefit description.

The terms and provisions of the Plan control the type and scope of benefits available to a covered person. No representative or agent of the Claims Administrator can amend the Plan or waive any of its provisions by giving oral advice, incomplete or incorrect information, or by contradicting the provisions of the Plan.

Reservation of Rights

Union College reserves the right to amend or terminate any of the plans or change contribution levels toward benefits at its discretion and for whatever reasons it considers appropriate. The Reservation of Rights provision pertains to all current, former and retired employees and applies to all insurance plans. No oral statement made by a representative of Union College may contradict this Reservation of Rights provision.

Inappropriate Behavior

If the covered person's behavior is disruptive, unruly, abusive, or uncooperative to the extent that if coverage continued, the Plan's ability to furnish services to either the covered person or other covered persons of the Plan would be seriously impaired, the Plan may terminate coverage for the covered person after not less than 10 days written notice from the Plan Administrator, subject to the Plan's appeal procedure.

False Information

The Plan may terminate coverage for a covered person, within 10 days written notice to the covered person and the Plan Administrator, for either of the following:

- The covered person submits materially incomplete or inaccurate information for the purpose of effecting coverage under the Plan or
- The covered person obtains or attempts to obtain benefits under the Plan by means of false, misleading, or fraudulent information, acts, or omissions.

Coverage Extension

If a covered person is confined to a hospital or institution on the covered person's employment termination date, coverage under the Plan will terminate on the employment termination date. HOWEVER, if a covered person remains confined and is determined by the CDPHN Medical Director to be totally disabled, coverage continues for the lesser of:

- until the medical condition which caused the hospitalization, has been alleviated;
- 6 months from the date the member's coverage is terminated;
- or until the member is covered by other insurance or a group health plan which provides coverage for the disabling condition;
- coverage includes the remainder of the hospitalization.

Prenatal and postnatal care are not considered confinement. Therefore, the Plan will not continue coverage past the termination date for a covered person receiving prenatal or postnatal care.

Misuse of ID Card

ID cards issued to covered persons are solely for identification. Possession of a card does not ensure eligibility and confers no rights to services or other benefits.

The holder of an ID card must be a covered person for whom any required contributions under the Plan have been paid.

If a covered person permits the use of his/her ID card by any other person, the card will be reclaimed by the Plan and all rights of the covered person and his/her dependents under the Plan will be immediately terminated. Notice of termination will be sent to the Plan Administrator.

Payment for services or other benefits received improperly through the use of an ID card is the financial obligation of the individual or individuals who used the ID card improperly.

General Information

All rights to covered benefits will end on the last day of the month following termination of employment.

Failure to report the termination of coverage to the Plan Administrator shall not continue such coverage beyond the date it is scheduled to terminate according to the terms of the Plan.

The Plan reserves the right to recover from the participant any benefits paid by the Plan for expenses incurred by the participant or any of his/her beneficiaries after termination of their coverage under the Plan.

If the participant fails to reimburse the Plan for any amounts paid following the covered person's termination, the participant and any dependent(s) will not be eligible to re-enroll, in any capacity, until such reimbursement to the Plan has been made.

Termination of a covered person's coverage will not affect any pending claim. A pending claim will include only those services and supplies provided before the termination date.

The provisions of this Section are subject to the provisions of the Continuation of Coverage Section, in this chapter, as applicable.

Health Insurance Portability and Accountability Act (HIPAA)

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. Under HIPAA, the College is required to provide "Certificates of Prior Credible Coverage" for previous health insurance coverage. You may need to provide this certificate if medical

advice, diagnosis, care or treatment was recommended or received for a condition within the six (6) month period prior to your enrollment in a new plan. When you become covered under another health plan, check with the plan administrator to see if you need to provide this certificate. You may need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

In addition to establishing standards for electronic health care transactions and unique national identifiers, Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides the legal standards for the privacy and security of protected health information (PHI). PHI includes information that we have created or received about your past, present or future health or medical condition that could be used to identify you. All employee protected health information (PHI) is maintained in a manner consistent with the privacy standards established by HIPAA. Further, Union College will provide you with a Notice of Privacy Practices, which describes how Union College uses information about you and when we can share that information with others in addition to how you can get access to this information.

Schedule A

The following persons have been designated by the Employer as authorized to use or disclose Protected Health Information for purposes of the Plan and have received appropriate training regarding the Plan's health information privacy policies and procedures and the applicable requirements of the Privacy Regulations.

Director Human Resources, Associate Director Human Resources

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

Complaints and Appeals

Resolving Differences.

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

How to File a Complaint.

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

To file a complaint by phone, call the CDPHN member services department at (518) 641-3100 or 1-877-724-2579 Monday-Friday from 8 a.m. to 5 p.m. If more information is needed to make a decision, CDPHN will advise you.

To file a written complaint write CDPHN a letter, or ask CDPHN for a complaint form to fill out. To get a complaint form, call CDPHN at (518) 641-3100 or 1-877-724-2579. Mail your complaint (form or letter) to:

CDPHN Appeals and Complaint Department
500 Patroon Creek Blvd.
Albany, NY 12206-1057

What Happens Next?

- Within fifteen work days after CDPHN receives your complaint they will send you a letter to let you know that staff is working on your complaint. This letter will include the name, address and telephone number of the individual who will answer your complaint. Qualified personnel will review your complaint, or if it's a medical matter, a licensed, certified, or registered health care professional will investigate.
- Upon receipt of your complaint, CDPHN will request in writing any other information needed from you or your provider to decide your complaint. If only part of that information is provided, CDPHN will ask for the missing information, in writing, within five work days of having received the partial information.
- CDPHN will give you or your designee a written decision on your complaint within 30 work days after having received your complaint, or within 30 days after all needed information is received, whichever is first. If CDPHN does not have all the information needed to decide your case by the 30th work day, they will send you a letter explaining why. CDPHN will then make a decision based on the information available, and inform you of the decision within the next 15 workdays.
- If a delay would significantly increase the risk to your health, CDPHN will decide your case and provide their decision by telephone within 48 hours after receiving all needed information, or 72 hours after receiving your complaint, whichever is first. CDPHN will send you written notice of the decision in three work days.
- All written decisions also tell you how to appeal if you wish, and include any forms you need.

CDPHN Policy

Description: CDPHN has implemented policies and procedures to ensure that all Participant appeals are documented, acknowledged, investigated, tracked, handled and resolved in a timely and fair manner and in compliance with the parameters established by the Plan. The policy and procedures listed are designed to accomplish this goal within the parameters established by the Plan.

Definitions CDPHN Appeals Committee—A multidisciplinary committee consisting of a representative from the Marketing and Participant Services Departments, and a representative who is licensed, certified or registered health care professional from CDPHN Medical Affairs Department.

Appeal—A verbal or written request by the Participant or the Participant's designee to review a determination, including benefit requests, and adverse utilization review determinations and claims payments made by CDPHN.

Appeals

1. A participant or the Participant's designee may file an Appeal with CDPHN within 60 days after receipt of written notice from the Claims or Resource Coordination Departments that a request for benefits referral, health care services or claims payment has been denied. The written denial notice must be set forth in a manner calculated to be understood by the Participant and contain the following information:

- the specific reason or reasons for the denial;
 - the specific reference to pertinent plan provisions on which the denial is based;
 - a description of any additional material or information necessary for the Participant to perfect his or 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 the denial of his or her benefit claim.
2. Upon receipt of an Appeal request, CDPHN will coordinate the review and investigation of all Appeals as follows:
 - CDPHN will provide written acknowledgement of the Appeal within fifteen (15) business days after receipt of the appeal.
 - a. This acknowledgement will include the name, address and telephone number of the individual designated to respond to the Appeal.
 - b. The Participant will also be notified of his or her right to review pertinent documents and to submit in writing issues and comments regarding his or her appeal.
 - CDPHN will request, in writing, any additional information required from the Participant or the provider after CDPHN's receipt of the Appeal. If CDPHN does not receive the required information within 30 calendar days, the case will be reviewed and a determination will be made based on the information available. If CDPHN does not have all the information needed to decide your case by the 30th work day, they will send you a letter explaining why. CDPHN will then make a decision based on the information available and inform you of the decision within the next 15 work days.
 - Qualified personnel will research and compile information necessary to evaluate the request.
 - Appeals pertaining to a clinical matter will be reviewed by one or more licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom will be a clinical peer reviewer.
 - The determination of an Appeal of a non-clinical matter will be made by qualified personnel at a higher level than the individual who made the initial determination.
 - All documentation related to the Appeal is maintained via electronic media. Documentation includes, but is not limited, to:
 - a. receipt date of the Appeal;
 - b. a copy of the Appeal request document, if such request was written;
 - c. a copy of all case related documentation;
 - d. the investigational activities and findings; and
 - e. the Appeal decision, including the date of the decision, the title(s) of the personnel and the qualifications of the clinical personnel who reviewed the case.
 - CDPHN will complete its review of the case and provide written notification to the Participant of the outcome of the Appeal within 30 days of receipt of the Appeal, or if special circumstances exist, no later than 45 days of receipt of the Appeal request.
 - The notice will include:

- the detailed reasons for the decision;
 - the clinical rationale, if applicable; and
 - specific reference to the pertinent sections of the SPD on which the Appeal decision is based.
3. • If your appeal remains denied the case will automatically go to the CDPHN Appeal Committee who will decide it within either (a) for pre-service claims, 30 days from the date of receipt of your appeal; or (b) for post-service claims, within 60 days of receipt of your appeal.
- If the CDPHN Committee upholds the denial you may have the right to an external review through an independent review organization if the denial involves a Medical Necessity, Experimental/ Investigational decision, or CDPHN turned down your request for a service on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network.
Your detailed Final Internal Adverse Determination letter will provide you with the necessary steps for requesting an external review. This letter will also include your ERISA rights.
 - For appeals that are upheld by CDPHN Committee that do not involve Medical Necessity, Experimental/ Investigational decision, or CDPHN turned down your request for a service on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network, a determination letter will be sent to you with your ERISA rights included.

Important Questions and Answers

Am I required to select a primary care physician? You are not required to select a Primary Care Physician, however, we still recommend that you establish yourself with a doctor who will deliver your routine services and coordinate your care with specialists. Please use Find-A-Doc at www.cdphp.com to view the range of doctors available within the CDPHP network. If your physician would like to participate in the network, CDPHN would be happy to provide him or her with information.

Will claim forms need to be filled out? You do not need to file a claim form for services received from an in-network provider because the provider will submit the claim form for you. You may need to submit claim forms for out-of-network services.

How do I submit a foreign medical claim? If you received medical treatment while traveling outside of the U.S., you will need to submit an itemized receipt to CDPHP for processing. The itemized receipt must include:

- Provider's name, address, telephone number, and tax ID number
- Date of service
- Name of each procedure/procedure code, including the name of any drugs
- Charge for each procedure
- Diagnosis
- Receipt for any payment made
- Member's name and ID number

The claim must include the above information in order to be considered for payment. CDPHP will have the foreign currency converted into U.S. dollars. If you have any concerns or questions, contact the CDPHP member services department.

Please send claim to: Capital District Physicians' Health Plan, Inc., P.O. Box 66602, Albany, NY 12206-6602.

Are prescription drug benefits available in this plan? Yes. The Union College PPO Plan U provides a benefit for prescription drugs through mail order and local pharmacies.

What if I am out of the area and need emergency care? Emergencies are covered worldwide.

Who can I contact if I need information about my benefits or the status of a specific claim? The Union College PPO Plan U claims are administered by CDPHN. Service representatives are available to assist you weekdays, 8:00 a.m. to 5:00 p.m. Call CDPHN at (518) 641-3100 or 1-877-724-2579 or you may utilize the CDPHN Web site at www.cdphp.com for the following:

- Clarification of benefits.
- Information on participating providers.
- To change your primary care physician.
- To inquire about the status of a claim.
- To report an incorrect or lost ID card.

For all other information, contact the Union College Human Resources office at (518) 388-6108.

Key Words to Understanding Care

Birthing Center: Any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than six to 10 hours); provide care under the full-time supervision of a physician and either a registered graduate nurse or a certified nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

Coinsurance. In the case of In-Network Benefits, Coinsurance is the balance of the charges you must pay after this Plan has paid a percentage of the charges for the covered services received under this Plan. In the case of Out-of-Network Benefits, Coinsurance is the percentage of the Reasonable and Customary Charge you must pay for the covered services you receive under this Plan.

Copayment: A set dollar amount which the participant is responsible to pay, usually at the time of service.

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

Deductible: The dollar value of covered expenses a participant must meet before benefits are paid.

Emergency: 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:

1. 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; or
2. Serious impairment to such person's bodily functions; or
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person. Examples of a medical emergency include a heart attack, a broken bone, a cut requiring stitches, difficulty breathing and unconsciousness.

Experimental and/or Investigational Care or Treatment:

Any treatment, procedure, facility, equipment, drug, device, or supply which the Plan Administrator does not recognize as accepted medical practice for the condition presented or which did not have required governmental approval for such condition at the time of treatment. Determination of the experimental/investigational issue will be made by the Plan Administrator in its sole discretion.

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

- The medical condition must be life-threatening, desperate, life-shortening or one that leads to paralysis or severe loss of bodily or motor functions.
- Conventional therapy does not exist or has failed.
- The risk-benefit ratio of patient outcome must be as favorable as that of established therapies or no treatment at all.
- The technology must be appropriate, in level of service and intensity, to the nature of the disease or condition being treated.
- Public policy would support the procedure(s) as a valid and ethical course of treatment.
- The technology is judged to be reasonably clinically effective according to reports in peer reviewed well controlled scientific literature and results are reproducible both within and outside of research settings.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed experimental and/or investigational. The decision of the Plan Administrator will be final and binding on the Plan.

Home Health Care Agency: Federally certified, state licensed (as required) agency whose main function is to provide home health care services and supplies.

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

Hospice Agency: A state licensed (as required) agency whose main function is to provide Hospice Care Services and Supplies.

Hospice Care Services and Supplies: Services and supplies provided through a Hospice Agency and under a Hospice care plan, including inpatient care in a hospice unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospital: An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and:

- Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Is approved by Medicare as a hospital.
- Maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians.
- Continuously provides on the premises 24 hour-a-day nursing services by or under the supervision of registered nurses.
- Operates continuously with organized facilities for operative surgery on the premises.

The definition of Hospital shall be expanded to include the following:

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of substance abuse if it meets these tests:
 - Maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients.
 - Has a physician in regular attendance.
 - Continuously provides 24-hour a day nursing service by a registered nurse.
 - Has a full-time psychiatrist or psychologist on the staff.
 - Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

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.

Intensive Care Unit: Defined as a separate, clearly designated service area which is maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a coronary care unit or an acute care unit. It includes:

- Facilities for special nursing care not available in regular rooms and wards of the Hospital.
- Special life-saving equipment which is immediately available at all times.
- At least two beds for the accommodation of the critically ill.
- At least one registered nurse in continuous and constant attendance 24 hours a day.

Medically Necessary: Service or supply which is required to diagnose or treat an injury, ailment, condition, disease, disorder, or illness of the covered person and which the Plan Administrator, in its sole discretion, determines is: appropriate with regard to the standards of good medical practice; not mainly for the convenience of the patient or the provider; and the most appropriate supply or level of service that can be provided to the patient safely. (When applied to the care of an inpatient, this means that the patient's condition and symptoms require that the services taken as a whole cannot be safely or adequately provided to the patient as Outpatient Care.)

Mental Illness: Any disease or condition that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Network: A group of providers who have agreed to treat employees and their covered dependents under a contract.

No-Fault Auto Insurance: The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Out-of-Network: Services received from a non-network provider without a referral from your primary care physician.

Outpatient Care or Services: Treatment, including services, supplies and medicines, provided and administered at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services, supplies and medicines rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical facility, or the patient's home.

Participant: The employee and his/her dependents who receive coverage through the employer-sponsored Plan.

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

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

Physician: An individual who is licensed as a Doctor of Medicine or Osteopathy and who is qualified to practice medicine under the applicable state law, or a partnership or professional association of such persons.

Prescription Drugs: Legend drugs that can only be legally dispensed when a physician orders them or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law. This includes, Medically Necessary enteral formulas which have been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer disorders, which, if left untreated, cause chronic disability, mental retardation or death, if prescribed by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law.

Primary Care Physician: One physician who is selected by the participant to coordinate medical care, including hospitalizations and referrals to specialists when necessary.

Reasonable and Customary Charge. A Reasonable and Customary Charge means a charge that CDPHN determines, in its sole discretion, is consistent with the charges of other providers of a given service in the community in which the service is rendered. A physician or other provider may charge a participant more or less than the Reasonable and Customary Charge, but the Plan will not reimburse the participant for charges above the Reasonable and Customary Charge. CDPHN's discretionary determinations as to what is the Reasonable and Customary Charge will be final and conclusive.

Referral System: The system within managed care that ensures all of a participant's medical care is coordinated. If a primary care physician determines that a participant needs services from a specialty physician, he or she will work with the participant to select a specialist who participates in the network, and will provide the participant with a referral.

Sickness: Illness and/or disease. For newborn child after birth, but before release from a medical facility, sickness also includes a congenital defect, a birth abnormality or premature birth.

Skilled Nursing Facility: A facility that:

- Is licensed to provide for persons convalescing from injury or sickness, and provides professional nursing services on an outpatient basis (The services must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.)

- Provides services for compensation under the full-time supervision of a physician or a registered nurse.
- Provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- Maintains a complete medical record on each patient.
- Has an effective utilization review plan.
- Is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally handicapped individuals, custodial or educational care or care of mental disorders.
- Is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent home or any other similar nomenclature.

Substance Abuse: The condition caused by regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco or caffeine.

Summary Plan Description Information

The name of the Plan is: The Union College PPO Plan U
Claims Administrator:

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057

Plan Year: January 1st–December 31st

Identification Numbers:

Employer #141338580

Plan Administrator and Agent for Service of Legal Process:

Union College
Human Resources
807 Union Street
Schenectady, New York 12308
(518) 388-6108

The cost of the Plan is shared by the employer and the employee and is subject to change.

The Plan's fiscal year ends on December 31st.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Union College, as Plan Administrator, has full authority to make final determinations as to all issues concerning eligibility for benefits under this Plan including full power to grant or deny benefits and to construe the provisions of this Plan.

This booklet is intended to comply with the Summary Plan Description requirements. Union College intends to continue the Plan but reserves the right to amend or terminate the Plan at any time.

Your Rights Under ERISA

The following statement of ERISA rights is required by Federal Law and rulings:

As a participant in the Union College PPO Plan U, 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) **filed** by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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.

Continue Group Health Plan Coverage

Participants may continue healthcare coverage for themselves, spouse, domestic partner, 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.

This plan does not have a reduction in benefits or a pre-existing condition exclusion. You should be provided a certificate coverage, free of charge, from your group health plan or health insurance issuer when you lose 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, your union, or any other person, may fire 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 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 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 plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

If you should have any questions about your Union College PPO Plan U, you should contact Union College Human Resources or the CDPHN account executive.



Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd. • Albany, NY 12206-1057 • (518) 641-3000