# GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

## BLUE SECURE
## BENEFIT BOOKLET

**Effective: January 1, 2023**

This benefit booklet ("Booklet") describes the benefits offered under the Blue Secure option of the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC" or "Plan"). In addition to the Blue Secure option described in this Booklet, the Plan offers the following other coverage options: Blue Traditional, Blue Secure, Blue Comprehensive, PPO Options (1, 2, 3, &4 ) and Metal Level Options (Bronze, Silver, Gold and Platinum. These other coverage options are described in separate booklets.

**The Plan is considered a municipal cooperative health benefit plan. The Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the New York State Superintendent of Financial Services. Municipal corporations participating in the Plan are subject to contingent assessment liability.**

Benefits described in this Booklet are offered to eligible retirees of participating counties and municipalities ("Participating Employers"), on the terms and conditions set forth herein. Not all Participating Employers that participate in the Plan offer all coverage options. Your employer will provide you with information regarding what coverage options are available to you. You may also contact the GTCMHIC for a listing of Participating Employers and the coverage options available to you by your Participating Employer.

The GTCMHIC has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the approval of the New York State Superintendent of Financial Services.

**READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS BOOKLET.**

If You need foreign language assistance to understand this Booklet, You may call the Claims Administrator at the number on Your ID card or Prescription Drug Benefit Manager (as applicable) at 877-635-9545.

Greater Tompkins County Municipal Health Insurance Consortium has adopted this Blue Secure Benefit Booklet, effective as of January 1, 2023.

**GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM**

______________________________
Signature

Rordan Hart
Printed Name

GTCMHIC Chairperson
Title

______________________________
Dated

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## SECTION ONE – INTRODUCTION

(1) **Your Coverage under the Plan.** Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Plan on behalf of the GTCMHIC and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association. In this Booklet, "you" and "your" mean the person named on the identification card issued by Excellus BlueCross BlueShield.

(2) **Medicare Coverage.** If you are not covered under Part A and Part B of Medicare, you are not eligible for coverage under the Plan. Payments will not be made under the Plan unless you are covered under both Part A and Part B of Medicare. In order to know what you are entitled to receive under the Federal Medicare program, you should read Your Medicare Handbook which is available at your local Social Security office.

(3) **Medical Necessity.** Except as otherwise provided in Section Five and Section Six, the Plan will provide coverage for the services described in this Booklet to the extent that the services are recognized as reasonable and medically necessary by Medicare.

## SECTION TWO – DEFINITIONS

**Appeal:** A request for the Plan to review a Utilization Review decision or a Grievance again.

**Claims Administrator:** Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Plan on behalf of the GTCMHIC and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.

**Claims Reviewer:** With respect to benefits covered under the medical sections of this Booklet, means the Claims Administrator. With respect to the Prescription Drug Coverage section of this Booklet, means the Prescription Drug Benefit Manager.

**External Appeal Agent:** An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

**Grievance:** A complaint that you communicate to the Plan that does not involve a Utilization Review determination.

**Medicare:** Title XVIII of the Social Security Act, as amended.

**Member:** A retiree of the GTCMHIC or a Participating Employer that is enrolled in the Plan and covered under this Booklet. Whenever a Member is required to provide a notice under any provision of this Booklet "Member" also means the Member's designee.

**Prescription Drug Benefit Manager.** ProAct, Inc.; 6333 Route 298, Suite 210, East Syracuse, NY 13057. Telephone No. 877-635-9545.

**Utilization Review:** The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

**You, Your:** The term "you" or "your" refers to you, the covered Member.

## SECTION THREE - HOSPITAL BENEFITS

Medicare is divided into three parts: hospital insurance (Part A), medical insurance (Part B) and prescription drug coverage (Part D). This section describes the payments the Plan will make which extend Medicare Part A insurance. Plan payments which extend Medicare Part B insurance are described in the section following this one.

Medicare will not pay the entire cost for all covered services. You must pay deductibles and copayments. A deductible is the first dollar amount of covered services Medicare does not pay. A copayment is your share of expenses for Medicare covered services.

(1) **Deductibles and Copayments for Hospitalization under Part A Of Medicare.** When you are in a hospital and you receive benefits under Part A of Medicare for that hospitalization, the Plan will pay for the following which Medicare does not pay:

A. The Medicare Part A deductible in each Benefit Period.

B. The daily copayment amount for the 61st through 90th day of each Benefit Period.

C. The daily copayment amount for the Medicare 60 lifetime reserve hospital days.

A Benefit Period begins when you enter a hospital. Successive stays in one or more hospitals or skilled nursing facilities count as one Benefit Period unless sixty (60) days or more elapse between the day of discharge and the next admission. When you enter a hospital after sixty (60) days have elapsed since the last discharge from the hospital or skilled nursing facility, a new Benefit Period starts.

When the Medicare Part A deductible and/or copayment amounts change, the benefits the Plan provides that cover these cost-sharing amounts will automatically change to coincide with the applicable changes in the Medicare Part A amounts.

(2) **Additional Hospital Days.** If during a Benefit Period you have used all your Medicare hospital days, including your Medicare lifetime reserve days, then the Plan will pay for 100% of your cost for additional days of inpatient hospital care in the same Benefit Period. The Plan will not pay for more than 365 of such additional days during your lifetime. Plan payment for each such additional day of inpatient care is subject to the following conditions:

A. It will be limited to those kinds of expenses which would have been paid under Medicare;

B. You are hospitalized in a short-term acute care general hospital which either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of Healthcare Organizations; and

C. Medicare would have made payment if you had not used all your Medicare days.

(3) **Part A Blood Deductible under Medicare.** When you are in a hospital or skilled nursing facility (SNF) and receive blood, Medicare may require you to pay non- replacement fees for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations). When Medicare covers your stay in the hospital or SNF and requires you to pay the Part A blood deductible, the Plan will cover this amount.

(4) **Copayments for Post-Hospital Skilled Nursing Facility Care under Part A of Medicare.** When you are confined in a SNF following hospitalization and you receive benefits under Part A of Medicare for that confinement, the Plan will pay the copayment amount from the 21st day through the 100th day in each Benefit Period. A Benefit Period is described in Paragraph 1 above.

(5) **Copayments for Hospice Care.** When you are receiving benefits for hospice care, including inpatient respite care, under Part A of Medicare, the Plan will pay the copayments for outpatient prescription drugs and the coinsurance for inpatient respite care.

## SECTION FOUR – MEDICAL BENEFITS

This section describes the payments the Plan will make which extend Medicare Part B insurance. Plan payments which complement Medicare Part A are described in the section before this one.

There are different deductibles and copayments under Part A and Part B of Medicare.

(1) **Deductibles, Copayments and Coinsurance for Medical Services under Part B of Medicare.** When you receive benefits covered under Part B of Medicare, the Plan will pay for the following which Medicare does not pay:

A. The Medicare Part B deductible in each calendar year.

B. When Medicare pays for a service covered under Part B of Medicare, the Plan will pay the copayment or coinsurance, if any, based on the amount approved by Medicare for the service. If Medicare pays 100% of the amount approved by Medicare for a service covered under Part B of Medicare, or Medicare pays nothing for any service, the Plan will not make any payment under this provision of this Booklet. Under no circumstances will the Plan make any payments for the difference between the amount approved by Medicare for a service covered under Part B of Medicare and the actual charge to you for the service.

When the Medicare Part B deductible, copayment and/or coinsurance amounts change, the benefits the Plan provides that cover these cost-sharing amounts will automatically change to coincide with the applicable changes in the Medicare Part B amounts.

(2) **Non-Assigned Medicare Claims.** If your provider does not accept Medicare's assignment, the Plan's payment is different.

When you receive benefits covered under Part B of Medicare from a non-assigned provider, in addition to Part B copayment described above, the Plan will also pay the Medicare excess charges. The Plan will pay 100% of the difference between Medicare's approved amount for Part B services and the actual charges billed by the provider, not to exceed any charge limitation established by the Medicare program or state law. If Medicare does not pay an expense, the Plan will pay nothing for that expense.

## SECTION FIVE – ADDITIONAL BENEFITS

(1) **Medically Necessary Emergency Care in a Foreign Country.** The Plan will pay for emergency care in a foreign country under the following terms and conditions:

A. Emergency care means care needed immediately because of an injury or an illness of sudden and unexpected onset.

B. You are responsible for a $250.00 deductible in each calendar year toward the expenses described in Paragraph C below for emergency care.

C. The Plan will pay 80% of billed charges after you have paid the deductible described in Paragraph B above for necessary emergency hospital, physician and medical care in a foreign country that would be covered under Medicare if you received the care within the United States.

D. The emergency care must begin during the first sixty (60) consecutive days of each trip outside the United States.

E. The Plan's payments for emergency care under this paragraph are subject to a lifetime maximum of $50,000.

F. The Plan will not pay for any emergency care you receive in a foreign country that is covered by Medicare, except that we will pay the deductibles and copayments as provided in Sections Three and Four.

(2) **External Hearing Aids.** The Plan will provide coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

A. Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a physician and include the hearing aid and the charges for associated fitting and testing. The Plan will cover a single purchase (including repair and/or replacement except for replacement, repairs and maintenance covered under warranty) of hearing aids for one (1) or both ears.

B. You are responsible for 50% coinsurance for each purchase.

C. The Plan will pay up to a maximum of $3,500 per ear based on the type of hearing aid prescribed.

D. Plan coverage is limited to one (1) hearing aid, per ear every three (3)

calendar years.

(3) **Vision Care.**

A. **Routine Eye Examination.** The Plan will provide coverage for a routine eye examination once every calendar year when provided by an optometrist or ophthalmologist.

B. **Eye Wear.** The Plan will provide coverage for eyeglass lenses and frames, or contact lenses ("contacts") instead of lenses and frames, once every calendar year when prescribed by an optometrist or ophthalmologist. However, the Plan will not provide benefits for sunglasses, even if ordered by your optometrist or ophthalmologist.

C. **Benefits.** Benefits for a routine eye exam are subject to a $20 copayment. The Plan will pay the billed charge for frames and lenses or contact lenses, up to a maximum of $100; you will be responsible for the payment of the balance of charges, if any.

(4) **Private Duty Nursing.** The Plan will provide coverage for Medically Necessary private duty nursing as an inpatient or in your home subject to the following conditions:

A. Services must be performed by a Licensed Practical Nurse (LPN), Registered Nurse (RN) or Licensed Vocational Nurse (LVN), licensed in the state in which the services are being performed.

B. If you are receiving services as an inpatient, the nurse must not be an employee or intern of the hospital or other facility where you are an inpatient.

C. If you are receiving services in your home, the nurse must not be a relative or a person living in your home.

D. The services performed must be consistent with the diagnosis, disease or condition for which you are being treated.

The Plan will pay 80% of the provider's charges for private duty nursing services, up to a maximum of $100 per day for up to 30 days per calendar year.

**Care Must Be Medically Necessary.** The Plan will provide coverage for private duty nursing as long as the service ("Service") is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Plan has to provide coverage for it.

The Plan will decide whether a Service was Medically Necessary. It will base its decision in part on a review of your medical records. The Plan will also evaluate medical opinions we receive. This could include the medical opinion of

a professional society, peer review committee or other groups of physicians.

In determining if a Service is Medically Necessary, the Plan will also consider:

- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending professional providers, which have credence but do not overrule contrary opinions; and
- Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
- They are required for the direct care and treatment or management of that condition;
- If not provided, your condition would be adversely affected;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of you, your family or the provider;
- They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and
- When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

**Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless the Plan determines that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section Ten for your right to an external appeal of the Plan's determination that a Service is not Medically Necessary.

## SECTION SIX – PRESCRIPTION DRUG COVERAGE

**Medically Necessary.** The Plan will provide coverage for Prescription Drugs covered under this section if it is Medically Necessary, as determined in accordance with the "Care Must be Medically Necessary" provision contained in Section Five of this Booklet.

**Covered Prescription Drugs.** The Plan covers Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a provider authorized to prescribe and within the provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On the Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with diagnosis and treatment of infertility, including in vitro fertilization.

- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending health care provider.

You may request a paper copy of the Formulary. The Formulary is also available at www.proactrx.com. You may inquire if a specific drug is covered under this Booklet by contacting the Prescription Drug Benefit Manager at 877-635-9545.

**Refills.** The Plan covers Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated Pharmacy as ordered by an authorized provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, the Plan allows for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost-sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Prescription Drug Schedule of Benefits section of this Booklet.

**Benefit and Payment Information.**

A. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Prescription Drug Schedule of Benefits section of this Booklet when covered Prescription Drugs are obtained from a retail, mail order or Designated Pharmacy.

You have a three (3) tier plan design. This means that your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier one and highest for Prescription Drugs on tier three. Your out-of-pocket expense for Prescription Drugs on tier two will generally be more than for tier one but less than tier three.

You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-covered Prescription Drug and the contracted rates (the Prescription Drug Cost) will not be available to you.

B. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, you are responsible for paying the lower of:

- The applicable cost-sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(your cost-sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that a Participating Pharmacy is unable to provide the covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, you may, with the Plan's prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. The Plan will pay you the Prescription Drug Cost for such approved Prescription Drug less your required Participating Pharmacy cost-sharing upon receipt of a complete Prescription Drug claim form. Contact the Prescription Drug Benefit Manager at 877-635-9545 or visit www.proactrx.com to request approval.

C. **Non-Participating Pharmacies.** The Plan will not pay for any Prescription Drugs that you purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies.** If you require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, the Plan may direct you to a Designated Pharmacy with whom the Plan has an arrangement with to provide those Prescription Drugs. However, the Plan will provide benefits that apply to Prescription Drugs dispensed by a designated pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as the designated pharmacy.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a provider; or have limited availability, special

dispensing and delivery requirements and/or require additional patient supports.

If you are directed to a designated pharmacy and you choose not to obtain your Prescription Drug from a designated pharmacy, you will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Acromegaly;
- Age related macular degeneration;
- AIDS wasting syndrome;
- Allergic Rhinitis;
- Amyloid cardiomyopathy;
- Anemia, neutropenia, thrombocytopenia;
- Ankylosing Spondylitis;
- Atopic Dermatitis;
- Cancer;
- Cardiovascular;
- Chorea associated with Huntington Disease;
- Chronic Granulomatous Disease;
- Crohn's disease;
- Cystic fibrosis;
- Duchenne's Muscular Dystrophy;
- Enzyme deficiencies;
- Gaucher's disease;
- Giant Cell Arteritis;
- Growth hormone related disorders;
- Hemophilia;
- Hepatitis B;
- Hepatitis C;
- Hereditary Angioedema;
- Heterozygous and Homozygous Familial Hypercholesterolemia;
- Hidradenitis Suppurativa;
- HIV/AIDS;
- Hormonal disorders such as endometriosis, precocious puberty, Cushing's Syndrome;
- Hyperkalemia;
- Idiopathic Pulmonary Fibrosis;
- Immune deficiency disorders;
- Infantile Hemangioma;
- Infertility;
- Inherited disorders of metabolism;
- Iron overload;
- Iron toxicity;
- Juvenile idiopathic arthritis;

- Lipodystrophy;
- Lupus;
- Migraine;
- Multiple sclerosis;
- Narcolepsy;
- Nephropathic Cystinosis;
- Neurogenic orthostatic hypotension;
- Neurologic disorders such as infantile spasms;
- Neurotrophic keratitis;
- Non 24-Hour Sleep Wake Disorder;
- Non-radiographic Axial Spondylitis;
- Osteoarthritis;
- Osteoporosis;
- Parkinson’s disease;
- Parkinson’s Induced Psychosis;
- Peanut Allergy;
- Peripheral stem cell collection;
- Primary Biliary Cholangitis;
- Psoriasis;
- Psoriatic arthritis;
- Pulmonary hypertension;
- Respiratory conditions such as asthma, eosinophilic granulomatosis with polyangiitis;
- Rheumatoid arthritis;
- RSV prevention;
- Seizure disorders such as infantile spasm and refractory complex partial seizures, Lennox-Gastaut syndrome, Dravet syndrome;
- Short bowel syndrome;
- Sickle Cell Anemia;
- Tardive Dyskinesia;
- Thrombocytopenia;
- Toxoplasmosis;
- Transplant;
- Ulcerative colitis;
- Vasoactive intestinal peptide tumors.

E. **Mail Order.** Certain Prescription Drugs may be ordered through the mail order pharmacy. You are responsible for paying the lower of:

- The applicable cost-sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your cost-sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize your benefit, ask your provider to write your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with

three (3) Refills). You will be charged the mail order cost-sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to your home or office.

You or your provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting www.proactrx.com or by calling the number for your Prescription Drug Benefit Manager at 877-635-9545.

F. **Formulary Changes.** The Formulary is subject to periodic review and modification. However, a Prescription Drug will not be removed from the Formulary during the calendar year, except when the FDA determines that such Prescription Drug should be removed from the market. Before a Prescription Drug is removed from the Formulary at the beginning of the upcoming calendar year, the Plan will provide at least 90 days' notice prior to the start of the calendar year. The Plan will also post such notice at www.proactrx.com.

The Plan will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a Prescription Drug on the Formulary during a calendar year unless the requirements are added pursuant to FDA safety concerns.

G. **Tier Status.** A Prescription Drug will not be moved to a tier with a higher cost-sharing during the calendar year, except a Brand-Name Drug may be moved to a tier with higher cost-sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time. Additionally, a Prescription Drug may be moved to a tier with a higher Copayment during the calendar year, although the change will not apply to you if you are already taking the Prescription Drug or you have been diagnosed or presented with a condition on or prior to the start of the calendar year which is treated by such Prescription Drug or for which the Prescription Drug is or would be part of your treatment regimen.

Before a Prescription Drug is moved to a different tier, the Plan will provide at least 90 days' notice prior to the start of the calendar year. If a Prescription Drug is moved to a different tier during the calendar year for one of the reasons described above, the Plan will provide at least 30 days' notice before the change is effective. You will pay the cost-sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status at by calling the Prescription Drug Benefit Manager at 877-635-9545.

H. **Formulary Exception Process.** If a Prescription Drug is not on the Formulary, You, your designee or your prescribing provider may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the External

Appeal section of this Booklet. Visit the www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545 to find out more about this process.

- **Standard Review of a Formulary Exception.** The Plan will make a decision and notify you or your designee and the prescribing provider by telephone no later than 72 hours after it receives your request. The Plan will notify you in writing within three (3) business days of receipt of your request. If your request is approved, the Plan will cover the Prescription Drug while you are taking the Prescription Drug, including any refills.

- **Expedited Review of a Formulary Exception.** If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you may request an expedited review of a Formulary exception. The request should include a statement from your prescribing provider that harm could reasonably come to you if the requested drug is not provided within the timeframes for the standard Formulary exception process. The Plan will make a decision and notify you or your designee and the prescribing provider by telephone no later than 24 hours after Our receipt of your request. The Plan will notify you in writing within three (3) business days of receipt of your request. If your request is approved, the Plan will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-Formulary Prescription Drug.

I. **Supply Limits.** Except for contraceptive drugs, devices, or products, the Plan will pay for no more than a 90-day supply of a Prescription Drug purchased at a retail pharmacy or designated pharmacy. You are responsible for one (1) cost-sharing amount for a 30-day supply and two (two) cost-sharing amounts for a 90-day supply. The cost-sharing amounts applicable to the Plan option you are enrolled in are identified in the Prescription Drug Schedule of Benefits.

You may have the entire supply (of up to 12 months) of the contraceptive drug, device or product dispensed at the same time. Contraceptive drugs, devices or products are not subject to cost-sharing when provided by a Participating Pharmacy.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for the cost-sharing amounts identified on the Prescription Drug Schedule of Benefits for the applicable Plan option you are enrolled in.

Some Prescription Drugs may be subject to quantity limits based on criteria that the Plan has developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing the

Prescription Drug Benefit Manager's website at www.proactrx.com or by calling 877-635-9545. If the Plan denies a request to cover an amount that exceeds the quantity level, you are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Booklet.

J. **Initial Limited Supply of Prescription Opioid Drugs.** If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for acute pain, and you have a Copayment, your Copayment will be prorated. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the seven (7) day supply, your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than your Copayment for a 30-day supply.

K. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply of your Prescription Order for certain drugs filled at a Designated Pharmacy instead of the full Prescription Order. You initially pay a lesser cost-sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are: Oncology, orphan drugs, inflammatory agents, and Multiple Sclerosis. This program applies for the first 60 days when you start a new Prescription Drug. This program will not apply upon you or your provider's request. You or your provider can opt out by visiting www.proactrx.com or by calling the number for the Prescription Drug Benefit Manager at 877-635-9545.

**Medical Management.** This Booklet includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before it can be determined that the Prescription Drug is Medically Necessary.

A. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask your provider to complete a Preauthorization form. Preauthorization is not required for covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to you.

The Prescription Drug Schedule of Benefits section of this Booklet, for the Plan option you are enrolled in, will include whether or not Preauthorization applies. If Preauthorization applies, for a list of Prescription Drugs that need Preauthorization, please visit www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545. The list will be reviewed and updated from time to time. The Plan also reserves the right to require Preauthorization for any new Prescription Drug on the market. However, the Plan will not add Preauthorization requirements to a Prescription Drug on the Formulary during a calendar year unless the requirements are added pursuant to FDA safety concerns. Your provider may check with the

Prescription Drug Benefit Manager to find out which Prescription Drugs are covered.

B. **Step Therapy**. Step therapy is a process in which you may need to use one (1) or more types of Prescription Drugs before the Plan will cover another as Medically Necessary. A "step therapy protocol" means the Plan's policy, protocol or program that establishes the sequence in which Prescription Drugs are approved for your medical condition. When establishing a step therapy protocol, the Plan will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. The Plan will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a Prescription Drug, you, your designee, or your provider can request a step therapy override determination as outlined in the Utilization Review section of this Booklet. The Plan will not add step therapy requirements to a Prescription Drug on the Formulary during a calendar year unless the requirements are added pursuant to FDA safety concerns.

**Limitations/Terms of Coverage.**

A. The Plan reserves the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If the Plan determines that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of Participating Pharmacies may be limited. If this happens, the Plan may require you to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single Participating Pharmacy. If you do not make a selection within 31 days of the date the Plan notifies you, the Plan will select a single Participating Pharmacy for you.

C. Compounded Prescription Drugs will be covered only when the primary ingredient is a covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $150 require your provider to obtain Preauthorization.

D. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

E. The Plan does not cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF or as otherwise provided in this Booklet. The Plan does not cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. The Plan does not cover repackaged products such as therapeutic kits or convenience packs that contain a covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

F. The Plan does not cover Prescription Drugs to replace those that may have been lost or stolen.

G. The Plan does not cover Prescription Drugs dispensed to you while you are a home care patient, except in those cases where the basis of payment by or on behalf of you to home health agency or home care services agency, , does not include services for drugs.

H. The Plan reserves the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Booklet.

I. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

**General Conditions.**

A. You must provide the pharmacy with identifying information that can be verified by the Prescription Drug Benefit Manager during regular business hours. You must include your identification number on the forms provided by the mail order pharmacy from which you make a purchase.

B. **Drug Utilization, Cost Management and Rebates.** The Plan conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost-effective manner.

In addition, as part of the utilization management activities, the Prescription Drug Benefit Manager (or its designee) may receive rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug

distributors or others and may share all or a portion of those rebates with the Plan. Any rebates received by the Plan may be used to offset or reduce administrative fees of the Plan. Rebates may also change or reduce the amount of any Member copayment or coinsurance applicable under the Prescription Drug coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim and your cost-sharing will not be adjusted if the later-determined rebate value is higher or lower than the estimate.

**Definitions.** Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Booklet).

A. **Brand-Name Drug:** A Prescription Drug that is manufactured, approved and marketed under a New Drug Application (NDA).

B. **Coinsurance:** Your share of the costs of a covered service, calculated as a percent of the Prescription Drug Cost for the service that you are required to pay to a provider.

C. **Copayment:** A fixed amount you pay directly to a provider for a covered Prescription Drug when you receive the Prescription Drug.

D. **Designated Pharmacy:** A pharmacy that has entered into an agreement with the Prescription Drug Benefit Manager or with an organization contracting on behalf of the Prescription Drug Benefit Manager, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

E. **Generic Drug:** A Prescription Drug that is manufactured, approved and marketed under an Abbreviated New Drug Application (ANDA).

F. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Booklet. To determine which tier a particular Prescription Drug has been assigned visit www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545.

G. **Hospital:** A short term, acute, general hospital facility, that is accredited as a hospital by JCAHO; is certified under Medicare, which:
- Is primarily engaged in providing, by or under the continuous supervision of physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);

- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

H. **Hospitalization:** Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

I. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with the Prescription Drug Benefit Manager to provide Prescription Drugs to Members. The Plan will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

J. **Participating Pharmacy:** A pharmacy that has:

- Entered into an agreement with the Prescription Drug Benefit Manager or its designee to provide Prescription Drugs to Members;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Been designated by the Plan as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

K. **Preauthorization:** A decision by the Plan prior to your receipt of a covered Prescription Drug is Medically Necessary. Covered Prescription Drugs that require Preauthorization are indicated in the Prescription Drug Schedule of Benefits sections of this Booklet.

L. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on the Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

M. **Prescription Drug Cost.** The amount, including a dispensing fee and any sales tax, the Plan has agreed to pay participating pharmacies for a covered Prescription Drug dispensed at a Participating Pharmacy. .

N. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed provider who is acting within the scope of his or her practice.

O. **Prescription Drug Schedule of Benefits**: The Prescription Drug Schedule of Benefits section of this Booklet, applicable to the Plan option you are enrolled in,

that describes the cost-sharing, Preauthorization requirements, and other limits on covered Prescription Drugs.

P. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

## SECTION SEVEN – EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Booklet, the Plan will not provide benefits for any service or care that is excluded from coverage under Medicare.

## SECTION EIGHT – CLAIM DETERMINATIONS

**Claims.**
A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. See the Coordination of Benefits section of this Booklet for information on how the Plan coordinates benefit payments when you also have group health coverage with another plan.

**Notice of Claim.**
In order to process your claim for benefits under this Booklet, the Plan must receive an "Explanation of Medicare Benefits" (EOMB) form either from you, the provider of service or Medicare. In addition, claims for services must also include all information designated by the Plan as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from the Claims Administrator or the Prescription Drug Benefit Manager by calling the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545. Completed medical claim forms should be sent to the Claims Administrator's address on Your ID card. Completed Prescription Drug claims should be sent to the Prescription Drug Benefit Manager at the following address: ProAct, Inc., 1230 US Hwy 11, Gouverneur, NY 13642. You may also submit a claim to the Claims Administrator or Prescription Drug Benefit Manager, as applicable, electronically by visiting its website.

**Timeframe for Filing Claims.**
Claims for services must be submitted to the Claims Reviewer, for payment within 12 months after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-month period, you must submit it as soon as reasonably possible.

**Claims for Prohibited Referrals.**
The Plan is not required to pay any claim, bill or other demand or request by a provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

**Claim Determinations.**
The claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, the claim determination procedure applies to contractual benefit denials. If you disagree with the claim determination, you may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and

External Appeal sections of this Booklet.

A. **Pre-Service Claim Determinations.**

- A pre-service claim is a request that a service or treatment be approved before it has been received. If the Claims Reviewer has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), it will make a determination and provide notice to you (or your designee) within 15 days from receipt of the claim.

  If the Claims Reviewer needs additional information, it will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the Claims Reviewer receives the information within 45 days, it will make a determination and provide notice to you (or your designee) in writing, within 15 days of receipt of the information. If all necessary information is not received within 45 days, the Claims Reviewer will make a determination within 15 calendar days of the end of the 45-day period.

- **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if the Claims Reviewer has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If the Claims Reviewer needs additional information, it will request it within 24 hours. You will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide notice to you (or your designee) by telephone within 48 hours of the earlier of receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

B. **Post-Service Claim Determinations.**
A post-service claim is a request for a service or treatment that you have already received. If the Claims Reviewer has all information necessary to make a determination regarding a post-service claim, it will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim if the Claims Reviewer denies the claim in whole or in part. If the Claims Reviewer needs additional information, it will request it within 30 calendar days. You will then have 45 calendar days to provide the information. The Claims Reviewer will make a determination and provide notice to you (or your designee) in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period if the claim is denied, in whole or in part.

**Payment of Claims.**
Where the Plan's obligation to pay a claim is reasonably clear, the Claims Reviewer will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If the Claims Reviewer requests additional information, the Plan will pay the claim within 15 days of the Claims Reviewer's determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the

information.

## SECTION NINE – GRIEVANCE PROCEDURES

**Grievances.**
The Plan's Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determinations. For example, it applies to contractual benefit denials or issues or concerns you have regarding administrative policies or access to providers.

**Filing a Grievance.**
You can contact the Claims Reviewer by phone at the number on your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. The Claims Reviewer may require that you sign a written acknowledgement of your oral Grievance, prepared by it based on your oral Grievance. You or your designee have up to 180 calendar days from when you received the decision you are asking the Claims Reviewer to review to file the Grievance.

When the Claims Reviewer receives your Grievance, it will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Grievance, and indicate what additional information, if any, must be provided.

The Claims Review keeps all requests and discussions confidential and the Plan nor the Claims Reviewer will take no discriminatory action because of your issue. The Plan has a process for both standard and expedited Grievances, depending on the nature of your inquiry.

You may ask that the Claims Reviewer send you electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell the Claims Reviewer in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit the Claims Reviewer's website. You can opt out of electronic notifications at any time.

A. **Grievance Determination.**
Qualified personnel will review your Grievance, or if it is a clinical matter, a licensed, certified or registered provider will look into it. The Claims Reviewer will decide the Grievance and notify you within the following timeframes:

| | |
|---|---|
| Expedited/Urgent Grievances: | By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance. |
| Pre-Service Grievances:<br>(A request for a service or treatment that has not yet been provided.) | In writing, within 15 calendar days of receipt of your Grievance. |

| | |
|---|---|
| Post-Service Grievances:<br>(A claim for a service or treatment that has already been provided.) | In writing, within 30 calendar days of receipt of your Grievance. |
| All Other Grievances:<br>(that are not in relation to a claim or request for a service or treatment.) | In writing, within 30 calendar days of receipt of your Grievance. |

B. **Second-Level Grievance (Appeal).**
If you are not satisfied with the resolution of your first level Grievance, you or your designee may file a second level Grievance (appeal) in writing to the following:

Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC)
Executive Director
Attn: Appeals Committee
P.O. Box 7
Ithaca, NY 14851

You have up to 120 calendar days from receipt of the first-level Grievance determination to file a second-level Grievance (appeal).

When the GTCMHIC Executive Director receives your second-level grievance (appeal), it will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your second-level Grievance (appeal) and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the first-level Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. The GTCMHIC Executive Director will decide the second-level Grievance (appeal) and notify you in writing within the following timeframes:

| | |
|---|---|
| Expedited/Urgent Grievances: | The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of your second-level Grievance (appeal). |
| Pre-Service Grievances:<br>(A request for a service or treatment that has not yet been provided.) | 15 calendar days of receipt of your second-level Grievance (appeal). |
| Post-Service Grievances:<br>(A claim for a service or | 30 calendar days of receipt of your second-level Grievance (appeal). |

| | |
|---|---|
| treatment that has already been provided.) | |
| All Other Grievances: (that are not in relation to a claim or request for service or treatment.) | 30 calendar days of receipt of your second level Grievance (appeal). |

C. **Assistance.**
If you remain dissatisfied with the GTCMHC Appeals Committee's second-level Grievance determination, or at any other time you are dissatisfied, you may:

**Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:**

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If you need assistance filing a first-level or second-level Grievance, you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

## SECTION TEN – UTILIZATION REVIEW

**Please note, the Utilization Review provisions described in this section only apply to additional benefits covered under this Booklet that are not covered under Medicare.**

**Utilization Review.**
The Plan reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, please call the Claims Reviewer at the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed physicians; or 2) licensed, certified, registered or credentialed providers who are in the same profession and same or similar specialty as the provider who typically manages your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed providers who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. The Claims Reviewer does not compensate employees or provide financial incentives to reviewers for determining that services are not Medically Necessary.

The Claims Reviewer has developed guidelines and protocols to assist in this process. The Plan will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call the Claims Reviewer at number on your ID card or visit the Claims Reviewer's website.

You may ask that the Claims Reviewer send you electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell the Claims Reviewer in advance if you want to receive electronic notifications. To opt into electronic notifications, call the Claims Reviewer's number on your ID card or visit the Claims Reviewer's website. You can opt out of electronic notifications at any time.

A. **Preauthorization Reviews.**

- **Non-Urgent Preauthorization Reviews.** If the Claims Reviewer has all the information necessary to make a determination regarding a Preauthorization review, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the request.

  If the Claims Reviewer needs additional information, it will request it within three (3)

business days. You or your provider will then have 45 calendar days to submit the information. If the Claims Reviewer receives the requested information within 45 days, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the information. If all necessary information is not received within 45 days, the Claims Reviewer will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

- **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if the Claims Reviewer has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If the Claims Reviewer needs additional information, it will request it within 24 hours. You or your provider will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within 48 hours of the earlier of receipt of the information or the end of the 48 hour period.

B. **Concurrent Reviews.**

- **Non-Urgent Concurrent Reviews**. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If the Claims Reviewer needs additional information, it will request it within one (1) business day. You or your provider will then have 45 calendar days to submit the information. The Claims Reviewer will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the information or, if the Claims Reviewer does not receive the information, within the earlier of one (1) business day of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

- **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, the Claims Reviewer will make a determination and provide notice to you (or your designee) and your provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

  If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and the Claims Reviewer has all the information necessary to make a determination, the Claims Reviewer will make a determination and provide written notice to you (or your designee) and your provider within the earlier of 72 hours or one (1) business day of receipt of the request. If the Claims Reviewer needs additional information, they will request it within 24 hours. You or your provider will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide written notice to you (or your designee) and your provider within the earlier of one (1) business day or 48 hours

of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

C. **Retrospective Reviews.**
If the Claims Reviewer has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If the Claims Reviewer needs additional information, it will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. The Claims Reviewer will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of receipt of all or part of the requested information or the end of the 45-day period.

Once the Claims Reviewer has all the information to make a decision, its failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

- **Retrospective Review of Preauthorized Services.**
  The Claims Reviewer may only reverse a preauthorized treatment, service or procedure on retrospective review when:

  (1) The relevant medical information presented to the Claims Reviewer upon retrospective review is materially different from the information presented during the Preauthorization review;
  (2) The relevant medical information presented to the Claims Reviewer upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to the Claims Reviewer;
  (3) The Claims Reviewer was not aware of the existence of such information at the time of the Preauthorization review; and
  (4) Had the Claims Reviewer been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

D. **Step Therapy Override Determinations.**
You, your designee, or your provider may request a step therapy protocol override determination for coverage of a Prescription Drug selected by your provider. When conducting Utilization Review for a step therapy protocol override determination, the Claims Reviewer will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

- **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a provider, demonstrating that:

  (1) The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to you;

(2) The required Prescription Drug(s) is expected to be ineffective based on your known clinical history, condition, and Prescription Drug regimen;
(3) You have tried the required Prescription Drug(s) while covered by the Plan or under your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
(4) You are stable on a Prescription Drug(s) selected by Your provider for Your medical condition, provided this does not prevent the Plan from requiring You to try an AB-rated generic equivalent; or
(5) The required Prescription Drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

- **Standard Review.** The Claims Reviewer will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your provider, within 72 hours of receipt of the supporting rationale and documentation.

- **Expedited Review.** If you have a medical condition that places your health in serious jeopardy without the Prescription Drug prescribed by your provider, the Claims Reviewer will make a step therapy protocol override determination and provide notification to you (or your designee) and your provider within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, the Claims Reviewer will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or your provider will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, the Claims Reviewer will make a determination and provide notification to you (or your designee) and your provider within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, the Claims Reviewer will make a determination and provide notification to you (or your designee) and your provider within the earlier of 72 hours or one (1) business day of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, the Claims Reviewer will make a determination and provide notification to you (or your designee) and your provider within the earlier of 72 hours of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, the Claims Reviewer will make a determination and provide notification to you (or your designee) and your provider within the earlier of 24 hours of receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If the Claims Reviewer does not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If the Claims Reviewer determines that the step therapy protocol should be overridden, the Plan will authorize immediate coverage for the Prescription Drug prescribed by your treating provider. An adverse step therapy override determination is eligible for an Appeal.

E. **Reconsideration.**
If the Claims Reviewer did not attempt to consult with your provider who recommended the covered service before making an adverse determination, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

F. **Notice of Adverse Determination**
A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for the Claim Reviewer's determination, date of service, provider name, claim amount (if applicable), and indicate that the diagnosis code and treatment code, and corresponding meaning of these codes, are available upon request. The notice will also advise you of your right to appeal the Claim Reviewer's determination, give instructions for requesting a standard or expedited internal Appeal and initiating an external appeal.

The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for the Claims Reviewer to review an Appeal and an explanation of why the information is necessary. The notice will also refer to the Plan provision on which the denial is based. The Claims Reviewer will send notices of determination to you (or your designee) and to your health care provider.

G. **Utilization Review Internal Appeals.**
You, your designee, and, in retrospective review cases, your provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. The Claims Reviewer will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your Appeal and, if necessary, inform you of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination

and who is 1) a physician or 2) a provider in the same or similar specialty as the provider who typically manages the disease or condition at issue.

H. **Standard Appeal.**

- **Preauthorization Appeal.** If your Appeal relates to a Preauthorization request, the Claims Reviewer will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

- **Retrospective Appeal.** If your Appeal relates to a retrospective claim, the Claims Reviewer will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

- **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. your provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

  If you are not satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external appeal.

  The Claims Reviewer's failure to render a determination of your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. **Notice of Determination of Internal Appeal.**
The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for the Claim Reviewer's decision. It will also explain your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external

appeal. The Claim Reviewer will send notices of determination to you or your designee and to your health care provider.

J. **Full and Fair Review of an Appeal.**
The Claim Reviewer will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claim Reviewer or any new or additional rationale in connection with your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

K. **Appeal Assistance.**
If you need Assistance filing an Appeal, you may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

## SECTION ELEVEN – EXTERNAL APPEAL

**Your Right to an External Appeal.**
In some cases, you have a right to an external appeal of a denial of coverage. If the Claims Reviewer has denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two (2) requirements:

A. The service, procedure, or treatment must otherwise be a covered service under this Booklet; and

B. In general, you must have received a final adverse determination through the internal Appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the internal Appeal process if:

- The Claims Reviewer agreed in writing to waive the internal Appeal. The Claims Reviewer is not required to agree to your request to waive the internal Appeal; or
- You file an external appeal at the same time as you apply for an expedited internal Appeal; or
- The Claims Reviewer fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Claims Reviewer demonstrates that the violation was for good cause or due to matters beyond its control and the violation occurred during an ongoing, good faith exchange of information between you and the Claims Reviewer).

**Your Right to Appeal a Determination that a Service is Not Medically Necessary.**
If the Claims Reviewer has denied coverage on the basis that the service is not Medically Necessary, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal above.

**Your Right to Appeal a Determination that a Service is Experimental or Investigational.**
If the Claims Reviewer has have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two (2) requirements for an external appeal above and your attending physician must certify that your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by the Plan; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one (1) of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

**Your Right to Appeal a Formulary Exception Denial.**
If the Claims Reviewer has denied your request for coverage of a non-formulary Prescription Drug through the formulary exception process, you, your designee or the prescribing provider may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug section of this Booklet for more information on the formulary exception process.

**The External Appeal Process.**
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If you are filing an external appeal based on the Claims Reviewer failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

The Claims Reviewer will provide an external appeal application with the final adverse determination issued through the internal Appeal process or with the Claims Reviewer's written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material

change from the information on which the Claims Reviewer based the denial, the External Appeal Agent will share this information with the Claims Reviewer in order for it to exercise its right to reconsider its decision. If Claims Reviewer chooses to exercise this right, it will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited external appeal (described below), the Claims Reviewer does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician, or the Claims Reviewer . If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

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

If your internal formulary exception request received a standard review through the Claims Reviewer’s formulary exception process, the External Appeal Agent must make a decision on your external appeal and notify you or your designee and the prescribing provider by telephone within 72 hours of receipt of your completed application. The External Appeal Agent will notify you or your designee and the prescribing provider in writing within two (2) business days of making a determination. If the External Appeal Agent overturns the Claims Reviewer's denial, the Plan will cover the Prescription Drug while you are taking the Prescription Drug, including any refills.

If your internal formulary exception request received an expedited review through the formulary exception process, the External Appeal Agent must make a decision on your external appeal and notify you or your designee and the prescribing provider by telephone within 24 hours of receipt of your completed application. The External Appeal Agent will notify you or your designee and the prescribing provider in writing within 72 hours of receipt of your completed application. If the External Appeal Agent overturns the Claims Reviewer’s denial, the Plan will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns the Claims Reviewer’s decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, the Plan will provide coverage subject to the other terms

and conditions of this Booklet. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the cost of services required to provide treatment to you according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Booklet for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both you and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

**Your Responsibilities.**
**It is your responsibility to start the external appeal process.** You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

**Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal Appeal, or the Claims Reviewer's failure to adhere to claim processing requirements. The Plan has no authority to extend this deadline.**

## SECTION TWELVE – COORDINATION OF BENEFITS

**Please note, the Coordination of Benefits provisions described in this section only apply to additional benefits Covered under this Booklet that are not covered under Medicare.**

This section applies to the benefits when You also have group health coverage with another plan. When You receive a Covered Service, the Plan will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

(1) **Definitions.**

A. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

B. **"Plan"** is other group health coverage with which the Plan will coordinate benefits. The term "plan" includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

C. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

D. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules

decide the order in which their benefits are determined in relation to each other.

(2) **Rules to Determine Order of Payment.**
The first of the rules listed below in paragraphs A-F that applies will determine which plan will be primary:

A. If the other plan does not have a provision similar to this one, then the other plan will be primary.

B. If the person receiving benefits is the Member and is only covered as a dependent under the other plan, this Plan will be primary.

C. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

D. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

E. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

F. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

(3) **Effects of Coordination.**
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not

exceed the Plan's maximum available benefit for each Covered Service. Also, the amount the Plan pays will not be more than the amount it would pay if it were primary. As each claim is submitted, the Plan will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

(4) **Right to Receive and Release Necessary Information.**
The Plan may release or receive information that it needs need to coordinate benefits. It does not need to tell anyone or receive consent to do this. The Plan is not responsible to anyone for releasing or obtaining this information. You must give the Plan any needed information for coordination purposes, in the time frame requested.

(5) **The Plan's Right to Recover Overpayment.**
If the Plan made a payment as a primary plan, You agree to pay the Plan any amount by which it should have reduced its payment. Also, the Plan may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help the Plan recover any overpayment.

(6) **Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.**
Except as described below, the Plan will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

a. If this Plan is primary, as defined in this section, the Plan will pay benefits first.

b. If this Plan is secondary, as defined in this section, the Plan will pay only the amount it would pay as the secondary insurer.

c. If the Plan requests information from a non-complying plan and do not receive it within 30 days, the Plan will calculate the amount it should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, it will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Plan is primary.

## SECTION THIRTEEN – TERMINATION OF YOUR COVERAGE

(1) **Termination of Coverage.** Coverage under the Plan will automatically be terminated on the first of the following to apply:

A. If you failed to pay premiums within 30 days of when the premium equivalent is due, coverage will terminate as of the last day for which premium equivalent payments were paid.

B. The end of the month in which you cease to meet the eligibility requirements for coverage under the Plan.

C. Upon your death, coverage will terminate.

D. The end of the month following the date the you provide written notice to the Plan requesting termination of coverage under the Plan, or on such later date requested for such termination by the notice.

E. If you (or someone acting on your behalf) has performed an act that constitutes fraud or the you (or someone acting on your behalf) has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Plan to you. However, if you make an intentional misrepresentation of material fact in writing on your enrollment application, the Plan will rescind coverage if the facts misrepresented would have led the Plan to refuse to provide the coverage under the Plan. Rescission means that the termination of your coverage will have a retroactive effect of up to your enrollment date under the Plan.

F. If the Plan elects to terminate or to stop offering all hospital, surgical and medical expense coverage, the Plan will provide written notice to you at least 180 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

(2) **Benefits after Termination of Coverage.** If you are totally disabled on the date your coverage terminates, and you have received service or care while covered under this Booklet, whether or not benefits were payable under this Booklet for such service or care, for the illness, condition or injury which caused your total disability, the Plan will continue to provide benefits in accordance with the terms and conditions of this Booklet. Benefits will be paid during an uninterrupted period of disability as follows:

A. With respect to benefits provided under this Booklet which complement Part A of Medicare, until the end of the Benefit Period if you are confined in a hospital or skilled nursing facility on the date your coverage under the Plan

terminates, or 12 months from the date your coverage under this Booklet terminates, whichever date shall first occur.

B. With respect to all other benefits provided under the Plan, until December 31st of the calendar year in which your coverage under this Booklet terminates.

A loss shall commence when a medical service, whether or not covered by the Plan, is rendered for the condition causing the total disability. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## SECTION FOURTEEN – GENERAL PROVISIONS

(1) **Assignment.**

You cannot assign any benefits or monies due under the Plan to any person, corporation or other organization. Payments under the Plan that complement Part B of Medicare are not assignable to anyone other than a provider of service who has accepted a Medicare assignment. Payments under the Plan that complement Part A of Medicare may, in the Plan's discretion, be paid to you or directly to the provider of service. Any attempt to assign payments other than described above will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Booklet or your right to collect money from the Plan for those services.

(2) **Certification of Compliance with Privacy Regulations:**

A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information that is maintained or received by the Plan. Such information is referred to as Protected Health Information (PHI) in this section. A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices (Privacy Notice) you received when you enrolled. A copy of the Privacy Notice is available upon request from the GTCMHIC or your Participating Employer.

Under HIPAA you have certain rights with respect to your PHI, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the PHI under certain circumstances.

The Plan may disclose PHI to a Participating Employer or allow the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) to make a disclosure to the Participating Employer as follows:

A. **Summary Health Information*.*** The Plan (or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose PHI that is summary health information to the Participating Employer, if the Participating Employer requests the summary health information for the purpose of obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan or amending the Plan. "Summary health information" is Plan information that summarizes claims information for the Plan from which most individual identifying information has been removed.

B. **Enrollment Information.** The Plan(or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose to the Participating Employer information on whether an individual is participating in the Plan.

C. **Other Disclosures to a Participating Employer.** Except as provided

above or under the terms of an applicable individual authorization, the Plan (or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose PHI to the Participating Employer, provided that the Participating Employer agrees to the following, which the Participating Employer has done by executing the Greater Tompkins Municipal Cooperative Health Benefit Plan Municipal Corporation Agreement:

(1) the Participating Employer will not use or further disclose PHI other than as permitted by the Plan or as required by law;

(2) the Participating Employer will ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Participating Employer with respect to such information;

(3) the Participating Employer will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Participating Employer;

(4) the Participating Employer will report to the Plan any use or disclosure, of which it becomes aware, of PHI that is inconsistent with the uses or disclosures permitted under the Plan;

(5) the Participating Employer will make PHI available to the individual who is the subject of that information in accordance with the Privacy Regulations;

(6) the Participating Employer will consider requested amendments to an individual's PHI in accordance with the Privacy Regulations;

(7) the Participating Employer will make available the information required to provide an accounting of disclosures of PHI in accordance with the Privacy Regulations;

(8) the Participating Employer will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(9) the Participating Employer will, if feasible, return or destroy all PHI received from the Plan that the Participating Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Participating Employer will limit further uses and disclosures to

those purposes that make the return or destruction of the information infeasible; and

(10) the Participating Employer will ensure that the adequate separation of the Plan and the Participating Employer as required in this section is established.

D. **Prohibited Disclosures.** The Plan will not disclose PHI to the Participating Employer for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Participating Employer.

E. **Separation of Health Plan and the Participating Employer.** The Participating Employer has designated and trained certain employees to be the only employees of the Participating Employer who will have access to PHI. Only those trained and authorized employees will use or disclose PHI on behalf of the Plan and only to the extent appropriate for performing administrative services that the Participating Employer provides for the Plan.

The Participating Employer will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Participating Employer who have access to PHI use that PHI only for the purposes specified in this section.

F. **Privacy Notice.** The Plan will comply with the applicable requirements of the Plan's Privacy Notice, which is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan. You may request a copy of the Notice of Privacy Practices from the Participating Employer or the Privacy Officer.

G. **Security Regulations.** The Plan (or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) will comply with all applicable requirements of the HIPAA Security Regulations.

In addition, the Participating Employer agrees that it will:

(1) Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Participating Employer on behalf of the Plan;

(2) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the

confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(3) Ensure that the adequate separation of the Participating Employer and the Plan required by the Privacy Regulations is supported by reasonable and appropriate security measures;

(4) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect that information; and

(5) Report to the Plan any security incident of which it becomes aware.

H. **Breach Reporting.** The Participating Employer will promptly report to the Plan any breach of unsecured PHI of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HIPAA Security Breach Regulations.

**Choice of Law.**
This Booklet shall be governed by the laws of the State of New York.

**Clerical Error.**
Clerical error, whether by the GTCMHIC, Participating Employer, Claims Administrator or Prescription Drug Benefit Manager, with respect to this Booklet, or any other documentation issued in connection with this Booklet, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

**Enrollment.**
The Participating Employers will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Members covered under this Booklet, and any other information required to confirm their eligibility for coverage. The Plan will provide the Claims Administrator and Prescription Drug Benefit Manager with your enrollment information, including your name, address, age, and social security number and advise the Claims Administrator and Prescription Drug Benefit Manager in writing when you are to be added to or subtracted from the list of Members, on a monthly basis.

**Furnishing Information and Audit.**
All persons covered under this Booklet will promptly furnish the Claims Administrator and/or Prescription Drug Benefit Manager with all information and records that it may require from time to time to perform its obligations under this Booklet. You must provide the Claims Administrator and/or Prescription Drug Benefit Manager with information over the telephone for reasons such as the following: to determine the level of care you need; so that the Claims Review may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

**Identification Cards.**
Identification ("ID") cards are issued by the Claims Administrator for identification purposes only. Possession of any ID card confers no right to services or benefits under this Booklet. To be entitled to such services or benefits, the Member's premium equivalents must be paid in full at the time the services are sought to be received.

**Incontestability.**
No statement made by you will be the basis for avoiding or reducing coverage unless it is in writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties.

**More Information about Your Plan.**
You can request additional information about your coverage under this Booklet by contacting the GTCMHIC, your Participating Employer, the Claims Administrator or Prescription Drug Benefit Manager. Examples of information you may request are as follows:

- A copy of the drug formulary. You may also inquire if a specific drug is covered under this Booklet.
- A copy of the medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating hospitals.
- A copy of the clinical review criteria(e.g., Medical Necessity criteria), and where appropriate, other clinical information the Plan may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Plan.

**Non-Duplication of Medicare Benefits.**
Coverage under the Plan shall not duplicate any benefits provided under Medicare.

**Notice.**
Any notice given to you under this Booklet will be mailed to your address as it appears on the Claims Administrator or Prescription Drug Benefit Manager's records or delivered electronically if you consent to electronic delivery. If notice is delivered to you electronically, you may also request a copy of the notice from the Plan or the Claims Administrator or Prescription Drug Benefit Manager (as applicable). you agree to provide the Claims Administrator or Prescription Drug Benefit Manager (as applicable) with notice of any change of your address. If you have to give the Claims Administrator or Prescription Drug Benefit Manager (as applicable) any notice, it should be sent by U.S. mail, first class, postage prepaid to the address of the Claims Administrator at 165 Court Street, Rochester, NY 14647 or the Prescription Drug Benefit Manager at the address identified in the Definitions section of this Booklet.

**Recovery of Overpayments.**
On occasion, a payment may be made to you when you are not covered, for a service that is not covered, or which is more than is proper. When this happens, the Plan will explain the problem to you and you must return the amount of the overpayment to the Plan within 60 days after receiving notification from the Plan. However, the Plan shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless it have a reasonable belief of fraud or other intentional misconduct.

**Right to Develop Guidelines and Administrative Rules.**
The Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) may develop or adopt standards that describe in more detail when the Plan will or will not make payments under this Booklet. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) and they will explain the standards or send you a copy of the standards. The Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) may also develop administrative rules pertaining to enrollment and other administrative matters. The GTCMHIC shall have all the powers necessary or appropriate to enable it to carry out its duties with the administration of the Plan, and may delicate such duties. The GTCMHIC has delegated claim processing authority to the Claims Administrator and Prescription Drug Benefit Manager (as applicable).

The Claims Administrator and Prescription Drug Benefit Manager (as applicable) review and evaluate new technology according to technology evaluation criteria developed by its medical directors and reviewed by a designated committee, which consists of providers from various medical specialties. Conclusions of the committee are incorporated into medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a covered benefit.

**Right to Offset.**
If the Plan makes a claim payment to you or on your behalf in error or you owe the Plan any money, you must repay the amount you owe the Plan. Except as otherwise required by law, if the Plan owes you a payment for other claims received, the Plan has the right to subtract any amount you owe it from any payment the Plan owes you.

**Service Marks.**
Excellus Health Plan, Inc. (“Excellus”) is an independent corporation organized under the New York Insurance Law. Excellus also operates under licenses with the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross Blue Shield Association. Excellus is solely responsible for the obligations created under the Administrative Service Contract between the GTCMHIC and Excellus.

**Services will not be Denied Based on Gender Identity**. The Plan will not limit coverage or impose additional cost sharing for any otherwise-covered Services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an

individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the gender for which such health services are ordinarily available. In such cases, the Plan generally will rely on recommendations of the treating physician, the Claims Administrator or Prescription Drug Benefit Manager (as applicable) medical policies, and applicable legal guidance to determine if a particular service is Medically Necessary.

**Severability.**
The unenforceability or invalidity of any provision of this Booklet shall not affect the validity and enforceability of the remainder of this Booklet.

**Subrogation and Reimbursement.**
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and the Plan has provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, the Plan may be subrogated to all rights of recovery against any such party (including your own insurance carrier) for the benefits the Plan has provided to you under this Booklet. Subrogation means that the Plan has a right, independently of you, to proceed directly against the other party to recover the benefits that the Plan has provided.

Subject to applicable state law, unless preempted by federal law, the Plan may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for the Plan provided benefits. Under New York General Obligations Law Section 5-335, the Plan's right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take any action against the Plan's rights or violate any contract between you and the Plan. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the Plan provided benefits.

The Plan requests that you notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by you for which the Plan has provided benefits. You must provide all information requested by the Plan or its representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request.

You agree to cooperate with the Plan's reimbursement and subrogation rights as the Plan may request and you agree not to prejudice the Plan's rights under this provision in any manner.

**Time to Sue.**
No action at law or in equity may be maintained against the Plan prior to the expiration of 60 days after written submission of a claim has been furnished to the Plan as required in this Booklet. You must start any lawsuit against the Plan under this Booklet within two (2)

years from the date the claim was required to be filed.

**Translation Services.**
Translation services are available free of charge under this Booklet for non-English speaking Members. Please contact the Claims Administrator at the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545 to access these services.

**Venue for Legal Action.**
If a dispute arises under this Booklet, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against the Plan in a court anywhere else. You also consent to New York State courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order you to defend any action the Plan may bring against you.

**Who May Change this Booklet.**
This Booklet may not be modified, amended, or changed, except in writing and signed by the GTCMHIC or a person designated by the GTCMHIC. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Booklet in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the GTCMHIC or person designated by the GTCMHIC.

**Your Medical Records and Reports.**
The Claims Administrator and Prescription Drug Benefit Manager is entitled to receive from any provider of services to Members, information reasonably necessary to administer the Plan subject to all applicable confidentiality requirements as defined in the General Provisions section of this Booklet. By accepting coverage under this Booklet, the Member authorizes each and every provider who renders services to a Member hereunder to:

- Disclose all facts pertaining to the care, treatment and physical condition of the Member to the Claims Administrator or Prescription Drug Benefit Manager (as applicable) or a medical, dental, or mental health professional that the Claims Administrator or Prescription Drug Benefit Manager (as applicable) may engage to assist it in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

- Render reports pertaining to the care, treatment and physical condition of the Member to the Claims Administrator and/or Prescription Drug Benefit Manager, or a medical, dental, or mental health professional, that it may engage to assist it in reviewing a treatment or claim; and

- Permit copying of the Member’s records by the Claims Administrator and/or Prescription Drug Benefit Manager (as applicable).

The Plan, the Claims Administrator and/or the Prescription Drug Benefit Manager (as applicable) acting on behalf of the Plan, agrees to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give the

Plan, the Claims Administrator and/or the Prescription Drug Benefit Manager (as applicable), acting on behalf of the Plan, permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Plan contracts to assist it in administering the Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

## PRESCRIPTION DRUG SCHEDULE OF BENEFITS – MS3

| | **PARTICIPATING PHARMACY** (Subject to the Prescription Drug Cost) **You Pay** | **NON-PARTICIPATING PHARMACY You Pay** |
|---|---|---|
| **Retail Pharmacy – 30-day supply** | | |
| Generic Drug (including diabetic drugs, equipment and supplies to the extent not covered under medical) | $10 Copayment | Not Covered |
| Brand Drug (including diabetic drugs, equipment and supplies to the extent not covered under medical) | $25 Copayment | Not Covered |
| Non-Preferred Brand Drug (other than diabetic drugs, equipment and supplies not covered under medical) | $40 Copayment | Not Covered |
| Non-Preferred Brand Diabetic Drugs, Equipment and Supplies (to the extent not covered under medical) | $35 Copayment | Not Covered |
| **Mail Order Pharmacy – 90-day supply** | | |
| Generic Drug | $20 Copayment | Not Covered |
| Preferred Brand Drug | $50 Copayment | Not Covered |
| Non-Preferred Brand Drug | $80 Copayment | Not Covered |
| Diabetic Drugs (to the extent not covered under medical) | Same Copayment as described above based on if the diabetic drug is a generic, brand or non-preferred brand drug | Not Covered |
| Diabetic Equipment & Supplies (to the extent not covered under medical) | Same Copayment as described above based on if the diabetic equipment & supply is a generic, brand or non-preferred brand drug | Not Covered |
| **Preauthorization Requirement.** Certain Prescription Drugs require Preauthorization. If You don't get Preauthorization, Your Prescription Drug will not be covered. You can view a list of Prescription Drugs that require Preauthorization by www.proactrx.com. You may also request a copy, free of charge by calling the Prescription Drug Benefit Manager at 877-635-9545. | | |
| **Step Therapy.** Step therapy applies. Refer to the Prescription Drug Coverage section (Section Six) of this Booklet for additional information regarding the step therapy program. | | |

## PRESCRIPTION DRUG SCHEDULE OF BENEFITS – MS4

| | **PARTICIPATING PHARMACY** (Subject to the Prescription Drug Cost) **You Pay** | **NON-PARTICIPATING PHARMACY You Pay** |
|---|---|---|
| **Retail Pharmacy – 30-day supply** | | |
| Generic Drug (including diabetic drugs, equipment and supplies to the extent not covered under medical) | $15 Copayment | Not Covered |
| Brand Drug (including diabetic drugs, equipment and supplies to the extent not covered under medical) | $30 Copayment | Not Covered |
| Non-Preferred Brand Drug (other than diabetic drugs, equipment and supplies not covered under medical) | $45 Copayment | Not Covered |
| Non-Preferred Brand Diabetic Drugs, Equipment and Supplies (to the extent not covered under medical) | $35 Copayment | Not Covered |
| **Mail Order Pharmacy – 90-day supply** | | |
| Generic Drug | $30 Copayment | Not Covered |
| Preferred Brand Drug | $60 Copayment | Not Covered |
| Non-Preferred Brand Drug | $90 Copayment | Not Covered |
| Diabetic Drugs (to the extent not covered under medical) | Same Copayment as described above based on if the diabetic drug is a generic, brand or non-preferred brand drug | Not Covered |
| Diabetic Equipment & Supplies (to the extent not covered under medical) | Same Copayment as described above based on if the diabetic equipment & supply is a generic, brand or non-preferred brand drug | Not Covered |
| **Preauthorization Requirement.** Certain Prescription Drugs require Preauthorization. If You don't get Preauthorization, Your Prescription Drug will not be covered. You can view a list of Prescription Drugs that require Preauthorization by visiting www.proactrx.com. You may also request a copy, free of charge by calling the Prescription Drug Benefit Manager at 877-635-9545. | | |
| **Step Therapy.** Step therapy applies. Refer to the Prescription Drug Coverage section (Section Six) of this Booklet for additional information regarding the step therapy program. | | |