

St. John's University Medical EPO Plan
Freedom Network
SJ00301
Summary Plan Description

January 1, 2015

Important Information

Reconstructive Breast Surgery Law

Effective October 21, 1998, group and individual benefit plans that cover mastectomies are required to cover reconstructive surgery or related services following a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998.

The Act guarantees coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. The Plan is required to provide coverage (as determined in consultation with the attending physician and the patient) for:

Individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided in the same manner as other medical and surgical benefits provided under this Plan. If you would like more information about this benefit, please read the enclosed Summary Plan Description.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance carriers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the carrier may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, carriers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a carrier may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Preauthorization. For information on Preauthorization, please contact Oxford Customer Service at the number on your Oxford ID card.

Notification of Language Assistance Program

Oxford understands that Oxford services an increasingly diverse membership. More than ever, Oxford believes that it is important to accommodate language preferences, especially when it comes to our Participants accessing care and services to ensure that language is not an obstacle to receiving proper care. Oxford offers language assistance services to limited English proficiency (LEP) Participants. Language assistance services are provided free of charge to Participants. If you need assistance or have any questions about these services, please call the number on the back of your ID card.

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SECTION 1. TELEPHONE AND ADDRESS REFERENCE GUIDE

Oxford wants you to be able to contact Oxford how, when and where you want to. Oxford's website www.oxhp.com is available 24 hours a day, seven days a week to obtain answers to your questions. If you need to reach Oxford by mail or telephone, it's important for you to know how. The following is a list intended to make your interactions with Oxford a little bit easier!

CLAIMS, 1st and 2nd LEVEL OF APPEALS

Oxford
P.O. Box 30432
Salt Lake City, UT 84130-0432
Submit claim forms to this address

1-800-444-6222 and
1-800 201-4911 (After 5:00
p.m)

EXTERNAL REVIEW

Oxford External Appeals Request Department
P.O. Box 29139
Hot Springs, AR 71903

1-800-444-6222 and
1-800 201-4911 (After 5:00
p.m)
1-877-814-8620
Fax number: 1-877-814-8620

MEDICAL EMERGENCIES AND URGENT CARE

Medical Management Coordinator

1-800-444-6222 and
1-800 201-4911 (After 5:00
p.m)

OXFORD CUSTOMER SERVICE

Customer Service Representatives are available
Monday- Friday 8:00 a.m. to 6:00 p.m.

1-800-444-6222 or the number
on the back of your ID card

PREAUTHORIZATION

1-800-444-6222

PHARMACY CUSTOMER SERVICE

1-800-905-0201

BEHAVIORAL HEALTH

1-800-201-6991

SECTION 2. INTRODUCTION

Welcome!

St. John's University is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

St. John's University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

Oxford is a private healthcare claims administrator and helps your employer to administer claims. Although Oxford will assist you in many ways, it does not guarantee any Benefits. St. John's University, the Plan Administrator, is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions, contact your Plan Administrator or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments by requesting printed copies by contacting your Plan Administrator.
- Capitalized words in the SPD have special meanings and are defined by Sections or in the Glossary.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in the Glossary.
- St. John's University is also referred to as Plan Sponsor or Plan Administrator.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

Who Can Join?

You are eligible to enroll in the Plan if you are a regular full-time employee who is entitled on his or her own behalf to participate in the medical and Hospital Benefits arranged by St. John's University.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse or Domestic Partner;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in the Section titled, *Other Important Information*.

Certain faculty members who are teaching abroad and designated by the University, who require medical care during the course of their assignment, will be reimbursed by the plan so that medical costs are no greater than those they would have incurred at an Oxford Network Provider.

Certain administrators who are aboard and designated by the University, can receive emergency medical care only during the course of their assignment.

How to Enroll

To enroll, notify your Plan Administrator within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment Period to make your Benefit elections.

Each year during annual Open Enrollment Period, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following plan year.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact your Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment Period to change your elections.

Cost of Coverage

You and St. John's University share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and the Plan Administrator reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling your Plan Sponsor.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Services related to that Inpatient Stay as long as you receive Covered Services in accordance with the terms of the Plan and the Covered Services are received on or after the day your coverage begins.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

When Coverage Begins

Once your Plan Administrator receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire or if you are hired on the first of the month, your coverage will begin immediately. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective on the date of your marriage, provided you notify your Plan Administrator within 31 days of your marriage. Coverage for Dependents acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify your Plan Administrator within 31 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who was enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact your Plan Administrator within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Plan Administrator within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your spouse; or

- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment Period.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in St. John's University's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under St. John's University's medical plan outside of annual Open Enrollment.

SECTION 3: HOW THE PLAN WORKS

Getting Started

This document contains a detailed description of your Plan. You should be familiar with all of the Plan's terms and conditions. They determine what coverage you have and what amounts the Plan will pay. Whenever you need Covered Services, the Plan gives you a choice.

This Plan provides access to Covered Services from Providers within Oxford's Freedom Network, which is Oxford's largest network. Under the Plan, you can choose to receive Covered Services "Network" from Oxford's Freedom Network Providers.

Your out of pocket responsibility differs depending upon whether Covered Services are obtained through your Network Benefits. Please refer to the *Plan Highlights* for specific out of pocket expenses.

Cost-Sharing Expenses And Eligible Expense

Your share of the costs will depend on the following:

1. Annual Deductible

Except where stated otherwise, if your Plan includes an Annual Deductible, the Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Services before the Plan will provide coverage. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Refer to *Plan Highlights* to determine if you have an Annual Deductible and how that Annual Deductible is applied.

2. Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Network Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

3. Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying for Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

4. Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Services. There are separate Network and Out-of-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Services through the end of the calendar year.

5. Eligible Expenses

“Eligible Expense” means the maximum amount the Plan will pay to a Provider for the services or supplies covered under this Plan, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. Oxford determines the Eligible Expense as follows:

- The Eligible Expense for Participating Providers will be the amount Oxford has negotiated with the Participating Provider.

See Emergency Services and Urgent Care section of the SPD for the Eligible Expense for an Emergency Condition.

Don't Forget Your ID Card

Remember to show your Oxford ID card every time you receive health care services from a Provider. If you do not show your Oxford ID card, a Provider has no way of knowing that you are enrolled under the Plan.

How Your Coverage Works

1. Network Services

As a Participant of the Plan, you may seek primary preventative or specialty care from any Network Provider without a referral. Specialty care will require a referral. You and your eligible Dependents may, but are not required to select a PCP. Oxford encourages you to use your PCP when you need primary or preventive Care. Oxford encourages you to allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

While referrals are not required, any requirements pertaining to Preauthorization, as described in this SPD, must be followed.

To receive the highest level of benefits, contact a Network Provider when you need medical assistance. In most instances, he or she will be able to provide the care you need. If you require services from another provider, be sure that he or she is also a Network Provider by checking the roster of Network Providers, or by calling Oxford.

If a Network Provider recommends Hospital or surgical services, they will need an approval from Oxford before you obtain those services. This process is referred to as Preauthorization. Before entering the Hospital, you may want to check with Customer Service to verify that the Hospital is a Network Provider and that the services have been Preauthorized.

Looking for a Network Provider?

In addition to other helpful information, www.oxhp.com, Oxford's consumer website, contains a directory of health care professionals and facilities in Oxford's Network. While Network status may change from time to time, www.oxhp.com has the most current source of Network information. Use www.oxhp.com to search for Providers available in your Plan.

2. Preauthorization

All admissions to health care facilities and certain diagnostic tests and therapeutic procedures must be Preauthorized by Oxford before you are admitted or receive treatment. If you are unsure whether a procedure requires Preauthorization, please call Oxford's Customer Service Department.

Preauthorization starts with a call to Oxford's medical management department by the Network Provider involved. One of Oxford's experienced Medical Management professionals examines the case, consults with your Network Provider and discusses the clinical findings. If all agree, the requested test, procedure or admission is Preauthorized. This comprehensive evaluation insures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective setting.

Covered inpatient services are Preauthorized for a specific number of days. If your Network Provider believes that a longer stay is Medically Necessary, the extension must be Preauthorized in order for it to be Covered.

Your Network Provider is responsible for obtaining any required Preauthorization. However, Oxford recommends that you call Customer Service to ensure that your services have been Preauthorized.

Please remember: Any Preauthorization you receive will not be valid if your coverage under the Plan terminates. This means that Covered Services received after your coverage has terminated will not be Covered even if they were Preauthorized.

3. Second Opinions

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, Oxford will refer you to a Network Provider for a second opinion.

In the event that the first and second opinions differ, a third opinion will be required. Oxford will designate a new Network Provider. The third opinion will determine whether or not the surgery is Preauthorized. There will be no cost to you for the second or third opinion. You may also request a second opinion.

4. Emergencies

If you have an Emergency, you should obtain medical assistance immediately or call 911. Emergency room care is not subject to Oxford's prior approval. **However, only Emergencies, as defined in this SPD, are Covered in an Emergency room.** Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care. You can call Oxford's medical management coordinators. They are available 24 hours a day, 7 days a week. The coordinator will direct you to the emergency room of a Hospital or other appropriate facility.

5. Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is Covered in or out of Our Service Area.

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center. You do not need to contact Oxford prior to, or after Your visit.

6. Diagnostic Testing and Laboratory Services

* Preauthorization is required

If your Network Provider recommends laboratory testing, remind him or her to use a Network Provider. In addition, Covered X-rays or diagnostic procedures performed at Network facilities will be Covered by the Plan without any required Copayment. Unless you are hospitalized, Hospitals are not Network Providers for these tests.

7. Customer Service

All coverage is subject to the terms and conditions contained in your Plan documents. You should understand your rights and obligations before you obtain services. If you have questions, Customer Service will be pleased to help you.

8. More Information

As a Participant, you automatically receive an SPD. Please note, you can request additional information about Oxford and your coverage under this SPD.

Selecting a Primary Care Physician

1. Selecting Your PCP

As described, you may be required to select a PCP when you enroll. Please refer to the roster of Network Providers when selecting a PCP.

2. Primary Provider of OB/GYN Care

In addition to a PCP, female Participants should select a Network Provider of OB/GYN Care.

3. Network Specialists as PCPs

Participants who have a life-threatening condition or disease and Participant who have a degenerative and disabling condition or disease may request to elect a Network Specialist as their PCP. The designated Network Specialist will become responsible for providing and coordinating all of the Participant's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures and provide referrals and medical services in the same capacity as a PCP.

This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. The desired Network Specialist must have the necessary qualifications and expertise to treat the Participant's condition or disease. A Participant may request this election at the time of enrollment or upon diagnosis.

4. Changing Your PCP

You may change your PCP (or Provider of OB/GYN Care) at any time. Select a new Provider from the roster of Network Physicians then call Customer Service to update your selection. The change will become effectively immediately.

Provider Participation, Access To Care And Transitional Care

1. Provider Participation

Oxford cannot promise that a specific Provider, even though listed in the roster of participating physicians, will be available. A Network Provider may end his or her contract with Oxford, or decide not

to accept additional patients. If you have any questions about whether or not a particular Provider is currently participating or accepting new patients, please feel free to call Customer Service and inquire. If your PCP or Network Specialist leaves Oxford's Network, you should choose another PCP or Network Specialist in order to continue receiving care on a Network basis. However, if you are undergoing a course of treatment at the time your Network Provider leaves the Network, you may be eligible for Transitional Care as described below.

2. Transitional Care

Your Provider Leaves the Network

If you are undergoing a course of treatment when your Provider leaves the Network, you may be able to continue to receive Covered Services for the ongoing treatment from your former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. Regarding pregnancy, if the Provider leaves the Network while you are in your second or third trimester, you may be able to continue care with a former Participating Provider through delivery and any post-partum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the Claims Administrator's relationship with the Provider. The Provider must also agree to provide Oxford necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, referrals, and a treatment plan approved by the Claims Administrator. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Participating Provider. You will only be responsible for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by the Claims Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

New Participants Currently Undergoing a Course of Treatment

If you are undergoing a course of treatment with a Provider at the time your coverage under this SPD becomes effective, you may be able to receive Covered Services from this Provider for up to 60 days from the effective date of your coverage under the SPD. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester or third trimester, you may receive Covered Services from this Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available **only if the Provider agrees to accept as payment Oxford's negotiated fees for such services**. Further, the Provider must agree to adhere to all of the applicable policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments.

In order to obtain Transitional Care, you or your Provider should call Medical Management at 1-800-444-6222 and request this coverage.

Patient/Provider Relationship

Network Providers are solely responsible for all health services that you receive. If you refuse to follow a recommended treatment, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither Oxford nor the Network Provider will have any further responsibility to provide Benefits for the condition under treatment.

Provider Reimbursement

Reimbursement

The Plan reimburses our Network Providers in a variety of ways. The most common is a discount off the Provider's usual fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider's name appears in Oxford's roster, which gives the Provider an opportunity to gain new patients from among our Membership.

SECTION 4: PLAN HIGHLIGHTS

Summary of Coverage

	Network
<u>Financial</u>	
Single Deductible:	\$500
Family Deductible:	\$1,000
Coinsurance:	10%
Maximum Out-of-Pocket (Single):	\$1,500
Maximum Out-of-Pocket (Family):	\$3,000
Lifetime Maximum Benefit: There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	
<u>Preventive Care</u>	
Adult Preventive Care	No Charge
Infant and Pediatric Preventive Care	No Charge
<u>Outpatient Care</u>	
Primary Care Physician Office Visits	\$20 copay per visit
Specialist Office Visits	\$30 copay per visit
Outpatient Facility Surgery**	Deductible & 10% Coinsurance
Laboratory Services**	No Charge
MRIs, MRAs, PET Scan, CT Scan, Ultrasound**	Deductible & 10% Coinsurance
Radiology Services**	Deductible & 10% Coinsurance

Hospital Care

Physician's and Surgeon's Services**	Deductible & 10% Coinsurance
Semi-Private Room and Board**	Deductible & 10% Coinsurance
All Drugs and Medications	Deductible & 10% Coinsurance

Emergency Care

Ambulance Service When Medically Necessary**	No Charge
At Hospital Emergency Room <i>(If member is admitted to the hospital, notification is required)</i>	\$100 copay, waived if admitted
Urgent Care Center	\$35 copay per visit

Maternity Care

Prenatal and Post-Natal Care**	No Charge
Hospital Services for Mother and Child**	Deductible & 10% Coinsurance

Skilled Nursing Facility

30 Days per Calendar Year**	Deductible & 10% Coinsurance
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Hospice Care

Inpatient Care**	Deductible & 10% Coinsurance
Home Hospice**	\$30 copay per visit

Home Health Care

Home Care Visits – 60 Visits per Calendar Year**	\$30 copay per visit
Physician House Calls**	\$30 copay per visit

Substance Use Disorder Services

Inpatient Rehabilitation**	Deductible & 10% Coinsurance
Outpatient Rehabilitation	\$30 copay per visit
Office Visits	\$30 copay per visit

Mental Health Care

Inpatient Care**	Deductible & 10% Coinsurance
Outpatient Care	\$30 copay per visit
Office Visits	\$30 copay per visit

Allergy Care

Testing and Treatment**	\$30 copay per visit
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Chiropractic Care

Chiropractic Care**	\$30 copay per visit
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Short Term Rehabilitation

60 Inpatient Days per Calendar Year**	Deductible & 10% Coinsurance
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90 combined Outpatient Visits per Calendar Year** \$30 copay per visit

*Preauthorization upon initial visit***

Durable Medical Equipment

Unlimited** Deductible & 10% Coinsurance

*Preauthorization required for items over \$500***

Medical Supplies When Medically Necessary

Medical Supplies When Medically Necessary Deductible & 10% Coinsurance

Exercise Facility

Participant \$200 reimbursement per 6 month period

Spouse \$100 reimbursement per 6 month period

Advanced Infertility Treatment (\$10,000 per lifetime)

Specialist Office Visits** \$30 copay per visit

Inpatient Facility Services** Deductible & 10% Coinsurance

Outpatient Facility Services** Deductible & 10% Coinsurance

Hearing Aids

Limited to a single purchase (including repair/replacement) every 3 years. Deductible & 10% Coinsurance

Prescription Drugs

Tier 1*** \$5 copay

Tier 2*** \$30 copay

Tier 3*** \$50 copay

Prescription Mail Order

Tier 1*** \$10 copay

Tier 2*** \$60 copay

Tier 3*** \$100 copay

Other Coverage

Vision Exam: One Exam every 12 months No Charge

Vision Hardware: One Set of Appliances every 24 months 50% of contracted rates

SECTION 5: COVERED SERVICES

What this section includes:

- Covered Services for which the Plan pays Benefits.

You will receive Covered Services in accordance with the terms and conditions of this SPD only when the Covered Service is:

- Medically Necessary;
- Properly Preauthorized, when required;
- Received while your coverage is in force;
- Not excluded under this SPD; and
- Not in excess of the benefit limitations described in this SPD.

All Covered Services are subject to the Copayments, Coinsurance and Deductibles specified under the *Plan Highlights*.

Important: The Plan reserves the right to provide benefits in the manner the Plan determines to be the most cost effective. Based on Oxford's medical policies, Oxford reserves the right to provide Benefits in the manner, and to the extent, Oxford believes is Medically Necessary.

Primary and Preventive Care

Primary Care consists of office visits, house calls and Hospital visits provided by your Provider for consultations, diagnosis and treatment of medical conditions, injury and disease that do not require the services of a specialist.

Preventive Care consists of the following services, performed by your Provider for the purpose of promoting good health and early detection of disease.

A. Preventive Care

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an alternate facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and
- with respect to women, Preventive care Benefits defined under the HRSA requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast

pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider or Physician.

B. Screening for Prostate Cancer

An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer is Covered.

C. Diabetic Equipment, Supplies and Education

Diabetic Supplies, Education and Self-Management are Covered as follows:

Supplies. The following equipment and related supplies will be Covered for insulin dependent and non-insulin dependent Participants when Medically Necessary as determined by the Participant's Physician:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired must be **Preauthorized by Oxford's Medical Director**)
- Cartridges for the visually impaired Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection Aides
- Injector (Busher) Automatic
- Insulin Cartridge Delivery
- Insulin Infusion Devices (Preauthorization is required for this item)
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets or gels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones

Additional items may also be Covered if the Participant's Physician determines they are Medically

Necessary and prescribes them for the Participant. Such additional items must be Preauthorized by one of Oxford's Medical Directors and be in accordance with the treatment plan developed by the Physician for the Participant.

Self-Management and Education: Education on self-management and treatment of diabetes is Covered: 1) upon the initial diagnosis; 2) if there is a significant change in the Participant's condition; or 3) the Physician decides that a refresher course is necessary. It must be provided:

- In a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
- Upon a Physician's referral to the following non-Physician, medical educators (qualified health providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians.
- Whenever possible, in a group setting, regardless of whether the Provider is a Physician or a qualified health provider. Education will also be provided in the Participant's home if the Participant is homebound.

D. Health Education

Health Education, information and health care literature which is made available to Participant's through various programs provided and developed by Oxford. These programs and information are provided without cost to Participants. Such programs include Oxford's Healthy Mother, Healthy Baby Program; Oxford's Better Breathing Program and Oxford's Healthy Mind, Healthy Body magazine.

Specialty Care

Specialty Care consists of medical care and services, including office visits, house calls, Hospital visits and consultations for the diagnosis and treatment of disease or injury as described below.

Please note: Most Specialty Care services require Preauthorization.

A. Surgical and Obstetrical Services.

*** Preauthorization required for certain services**

Physicians' services for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife are also Covered.

Hospital admissions, including maternity admissions, require Preauthorization. When possible, the Preauthorization should be obtained at least 14 days in advance of the service.

B. Maternity and Newborn Care.

Maternity Care

Services and supplies for maternity care provided by a Physician, licensed nurse midwife, Hospital or birthing center will be Covered for prenatal care (including one visit for genetic testing), postnatal care,

delivery and complications of pregnancy. The Plan provides a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Unless the admission to the Hospital or birthing center is made on an Emergency basis, the admission must be Preauthorized.

The mother has the option to leave the hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth.

The visit will occur within 24 hours of the later of: the mother's request; or her discharge from the hospital. This visit is not subject to deductible or Copayment. Additionally, the visit will not be deducted from the Home Health Care visits Covered under the SPD.

The home visit consists of a visit by a professional RN to provide the following post-delivery care: an assessment of the mother and child, instruction on breastfeeding, cleaning and care for child; and any required blood tests ordered by either the mother's or the child's Physician.

Network coverage for a routine delivery or maternity care outside of the service area is limited. Oxford defines a "routine delivery" as a full-term delivery that has occurred without any complications.

Newborn Care

*** Preauthorization required for certain services**

Care for newborns includes preventive health care services (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. The Plan also Covers, within the limits of this SPD, necessary transportation costs from the place of birth to the nearest specialized treatment center.

*Network, routine nursery and preventive Newborn Care does not require Preauthorization. Circumcision performed by a licensed medical practitioner during the delivery inpatient stay does not require Preauthorization. However, services that generally require Preauthorization (such as surgery) must be Preauthorized.

C. Treatment of Infertility

Basic Infertility Services

Basic Infertility Services will be provided to a Participant who, in Oxford's opinion, is an appropriate candidate for infertility treatment. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

Comprehensive Infertility Services

If the Basic Services do not result in increased fertility, Medical Management may Preauthorize Comprehensive Infertility Services. These services include: ovulation induction and monitoring with ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

Advanced Infertility Services

Should the Comprehensive Infertility Services fail to increase fertility, Oxford's Medical Director may Preauthorize the following Advanced Infertility Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

D. Allergy Testing and Treatment

The Plan Covers testing and evaluations, including injections, and scratch and prick tests to determine the existence of an allergy. The Plan covers allergy treatment, including desensitization treatments, routine allergy injections, including serums are Covered.

E. Habilitation Services

The Plan covers Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a health care professional's office. Refer to your Schedule of Benefits to determine if a limit applies to your plan.

F. Rehabilitation Services

Rehabilitation therapy including physical therapy, speech therapy, and occupational therapy, is Covered on an outpatient or inpatient basis. Coverage on an outpatient basis is limited to the amount of visits shown in the *Plan Highlights*. For the purposes of this benefit (both inpatient and outpatient), "per condition" means the disease or injury causing the need for the therapy. For Covered Services received under this benefit you are eligible to receive up to the specified amount for the singular condition as noted in the *Plan Highlights*. The accumulation of this limit is based on the "condition" and not the therapy type. Unrelated conditions are subject to separate maximums. A "session" is a period of time, up to 45 minutes, in which therapy is performed.

Speech or occupational therapy is Covered only when it is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered child, this includes a medically diagnosed congenital defect), it is ordered by a Physician and You have been Hospitalized or have undergone surgery for such illness or Injury.

Covered Services must begin within six months of the later to occur:

- the date of the injury or illness that caused the need for the therapy;
- the date the Participant is discharged from a Hospital where surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

And in no event will the therapy continue beyond 365 days after such event.

G. Reconstructive Breast Surgery

*** Preauthorization required for inpatient admissions**

The Plan Covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. The Plan also Covers implanted breast prostheses following a mastectomy or partial mastectomy.

H. Other Reconstructive and Corrective Surgery

*** Preauthorization required for inpatient admissions**

Reconstructive and corrective surgery is Covered only when it is:

- Performed to correct a congenital birth defect of child Covered under this Plan which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part;
- Otherwise Medically Necessary.

The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

I. Oral Surgery

General dental services are not Covered. The following limited dental and oral surgical procedures are Covered in either an inpatient or outpatient setting:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when the repair is not possible. Dental services must be obtained within 12 months of the injury. Accidental injury does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders TMJ and orthognathic surgery. Preauthorization is required.

Oral Surgery, including the dental services described above, requires Preauthorization. When possible, please obtain the Preauthorization at least 14 days in advance of the surgery or procedure.

J. Laboratory Procedures, Diagnostic Testing, Radiology Services and X-ray Examinations

The Plan Covers x-ray and laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services when performed on an outpatient basis.

Major diagnostic procedures require Preauthorization. It is important that you do not seek the services of a laboratory or imaging center without Preauthorization. If you do, you will be responsible for the costs of such services. Please contact Oxford before you obtain any of the procedures listed in the *Plan Highlights*.

K. Internal and External Prosthetic Devices

Internal Prosthetic Devices: The Plan Covers surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a Covered mastectomy. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs.

External Prosthetic Devices: The Plan Covers prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. The Plan Covers wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). The Plan does not Cover wigs made from human hair unless You are allergic to all synthetic wig materials..

The Plan does not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this Benefit.

The Plan does not Cover orthotics (e.g., shoe inserts).

For adults, The Plan Covers the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. The Plan does not otherwise Cover the cost of repairs or replacement.

For adults, The Plan Covers the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

The Plan Covers external breast prostheses following a Covered mastectomy which are not subject to any lifetime limit.

L. Durable Medical Equipment and Braces

*** Preauthorization is required for the purchase of Durable Medical Equipment or braces is required when the item will cost \$500.00 or more.**

Durable Medical Equipment. The Plan Covers the rental or purchase of durable medical equipment and braces. Durable Medical Equipment is equipment which is: 1) designed and intended for repeated use; 2) primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of disease or injury; and 4) is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. The Plan does not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. Oxford will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment. The Plan does not Cover customization of any item of Durable Medical Equipment.

Braces. The Plan Covers braces that are worn externally and that temporarily or permanently assists all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. Replacements are Covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. The Plan does not otherwise Cover the cost of repairs or replacement (e.g., the Plan does not Cover repairs or replacement that is the result of misuse or abuse by the Participant).

M. Medical Supplies

The Plan Covers medical supplies that are required for the treatment of a disease or injury which is Covered under this SPD. Maintenance supplies (e.g., ostomy supplies) for conditions. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. The Plan does not Cover over-the-counter medical supplies. Diabetic Supplies are not Covered under this provision. Please see the "Diabetic Supplies, Education and Self-Management" section of this SPD for a description of diabetic supply Coverage.

N. Transplants

The Plan Covers only those transplants that Oxford determines to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by your Specialist(s) and Preauthorized by Oxford's Medical Director. Additionally, all transplants must be performed at Hospitals that Oxford has specifically approved and designated to perform these procedures.

The Plan will Cover the Hospital and medical expenses, including donor search fees, of the recipient. The Plan will Cover transplant services required by a Participant when the Participant serves as an organ donor **only if the recipient is a Participant**. The Plan does not Cover medical expenses of a non-Participant acting as a donor for a Participant if the non-Participant's expenses will be covered under another health plan or program. The Plan will cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Oxford determines to be appropriate. Oxford will make the determination of when such treatment is medically appropriate.

The Plan does not Cover: travel expenses, lodging, meals or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; Or routine harvesting and storage of stem cells from newborn cord blood.

O. Home Health Care

*** Preauthorization required**

The Plan Covers care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency.

The care must be provided by Physician-supervised health professionals pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervisions of a registered professional nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs and medications prescribed by a Network Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Each visit up to four hours by a Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Refer to your Schedule of Benefits to determine if a limit applies to your Plan. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation Services".

P. Chemotherapy

The Plan Covers Chemotherapy in an outpatient Facility or in a health care professional's office. When Chemotherapy is provided in the office, Preauthorization is not required. See *Hospital and Other Facility-Based Services*, under the heading *Hospital Services* for inpatient coverage.

Q. Second Opinions

The Plan Covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an in-network basis when your attending Physician provides a written Referral to a Non-Participating Specialist.

Second Surgical Opinion. The Plan Covers a second surgical opinion by a qualified Physician on the need for surgery.

Required Second Surgical Opinion. Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be Covered. The second opinion must be given by a board certified Specialist who personally examines you. If the first and second opinions do not agree, you may obtain a third opinion. There is no cost to you when Oxford requests a second opinion.

In the event that the first and second opinions differ, you may obtain a third opinion. The second and third surgical opinion consultants may not perform the surgery on you. .

Second Opinions in Other Cases. There may be other instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that Oxford designate another Provider to render a second opinion. If the first and second opinions do not agree, Oxford will designate another Provider to render a third opinion. After completion of the second opinion process, Oxford will Preauthorize Covered Services supported by a majority of the Providers reviewing your case.

R. Chiropractic Services

The Plan will Cover spinal subluxation and related services when performed by a doctor of chiropractic (“Chiropractor”). This includes assessment, manipulation and any modalities.

This benefit remains subject to Medically Necessity. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this SPD.

S. Clinical Trials for Cancer or Disabling or Life Threatening Chronic Disease

The Plan will Cover the routine patient costs associated with a qualifying clinical trial for cancer or a disabling or life-threatening chronic disease.

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with Oxford's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. Oxford may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember, the Covered Service must be Preauthorized.

T. Hearing Aids

The Plan Covers 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.

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 Covers a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period of time the You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

U. Dialysis

The Plan Covers dialysis treatments of an Acute or chronic kidney ailment.

Hospital and Other Facility-Based Services

Please remember, in order to receive coverage for any facility based Covered Service, the Covered Service must be Preauthorized.

Hospital and Other Facility-Based Services

Please remember, in order to receive coverage for any facility based Covered Service, the Covered Service must be Preauthorized.

A. Hospital Services (Excluding Mental Health Services, Alcohol and Substance Abuse)

* Hospital admissions require Preauthorization. All Preauthorized admissions to Network Hospitals are Covered on a Network basis; regardless of whether or not the admitting Provider is a Network Provider.

Inpatient Services: Coverage Hospital Inpatient services for Medically Necessary, **acute-care** includes: semi-private room and board, unlimited days, general nursing care and the following additional facilities, services and supplies: meals and special diets; use of operating room and related facilities; use of intensive care or cardiac care units and related services; X-ray services; laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; short-term physical, speech and occupational therapy; radiation therapy; inhalation therapy; chemotherapy; whole blood and blood products; and the administration of whole blood and blood products.

Inpatient Stay for Lymph Node Dissection or Lumpectomy: The Plan will Cover Hospital inpatient services for Participants undergoing a lymph node dissection or lumpectomy. Coverage is available for the period of time determined to be Medically Necessary by you and your Physician.

Autologous Blood Banking Services: Autologous blood banking services are Covered only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, the Plan will Cover storage fees for what Oxford determines to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed.

Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.

Outpatient Services: The Plan Covers the inpatient Hospital services and supplies listed above that can be provided to you while being treated in the outpatient facility. **Please remember**, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for laboratory procedures and tests. **Please note:** lab work and X-rays performed in a Hospital on an outpatient basis do not require Preauthorization.

B. Ambulatory Surgery Center

Coverage is available for Covered surgical procedures performed at Ambulatory Surgical Centers. The Plan also Cover the Covered Services and supplies provided by the Center the day the surgery is performed.

C. Skilled Nursing Facility

*** This benefit requires Preauthorization and treatment plan.**

The Plan Covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. In addition to Preauthorization, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Oxford. The Plan Covers noncustodial care for the amount of days shown in the *Plan Highlights*. Coverage is limited to 100 days per calendar year.

D. Hospice

*** This benefit requires Preauthorization for services rendered inpatient or in the home.**

Hospice Care is available to Participants who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. The Plan Covers a total of 5 visits for supportive care and guidance for the purpose of helping the Participant and the Participant's immediate family cope with the emotional and social issues related to the Participant's death. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the appropriately certified or licensed state hospice agency. Such certified programs may include Hospice Care delivered by: a Hospital (inpatient or outpatient), Home Health Care Agency, Skilled Nursing Facility or a licensed Hospice facility.

Coverage is not provided for: funeral arrangements, pastoral, financial or legal counseling; homemaker, caretaker or respite care.

Emergencies

In order to obtain Coverage for Emergencies, you should follow the instructions below, regardless of whether or not you are in the Service Area at the time of the Emergency. Emergencies include Covered

Services provided by any health care provider as outlined below:

The Plan defines an Emergency as follows: a serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance abuse disorders which: (a) arise suddenly; and (b) in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

With respect to a pregnant Participant who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the mother or the unborn child. Some examples of an Emergency are:

Emergencies include, but are not limited to, the following conditions:

- Severe chest pains
- Severe shortness of breath
- Severe or multiple injuries
- Loss of consciousness
- Convulsions
- Severe bleeding
- Poisonings
- Sudden change in mental status (e.g., disorientation)
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis

Oxford reserves the right to review all appropriate medical records and make the final decision regarding the existence of an Emergency. Regarding such retrospective reviews, the Plan will Cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize an Emergency condition.

A. Hospital Emergency Room Visits

In the event of an Emergency, seek immediate care at the nearest emergency room or call 911.

Emergency room care is not subject to Oxford's prior approval. However, only Emergencies, as defined above, are Covered in an emergency room. If you would like assistance assessing the situation, you may call your Network Provider (if applicable). You can also call Oxford's Medical Management Coordinators or *Oxford-On-Call*. They are available 24 hours a day, 7 days a week. Your Network Provider or *Oxford-On-Call* will direct you to the emergency room of a Hospital or other appropriate facility.

Follow-up care provided in a Hospital emergency room is not Covered.

B. Emergency Hospital Admissions

In the event you are admitted to the Hospital, you or someone on your behalf must notify Oxford at the Emergency telephone number listed in the front of this SPD within 48 hours of your admission, or as soon as is reasonably possible.

It is important to remember that only those conditions that meet all of the requirements contained in the definition of Emergency will be Covered as an Emergency. Routine care received in an emergency room is not Covered.

C. Ambulance Services

*** This benefit may require Preauthorization**

Ambulance services for life-threatening Emergencies will be Covered. Ambulance services for all other Emergencies will be Covered when Medically Necessary.

The Plan also Covers pre-Hospital Emergency Medical Services. This means the Plan Covers the prompt evaluation and treatment of an Emergency in addition to non-air-borne transportation of the patient.

Inter-facility ambulance transfers will also be Covered if they receive Preauthorization.

D. Payments Relating to Emergency Services Rendered

The amount the Plan pays a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount the Claims Administrator has negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Eligible Expense for Services provided by a Non-Participating Provider (i.e., the amount the Claims Administrator would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance or Copayment.

Urgent Care

The Plan defines Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not an Emergency. Urgent Care is Covered in or out of the Service Area.

If an Urgent Care visit results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

Reimbursement and Copayments

When you receive Covered Services for an Emergency or Urgent Care situation from a Provider, outside of the Service Area, the Plan will limit reimbursement to the Usual, Customary and Reasonable Charges for those expenses incurred up to the time the Participant is determined to be able to travel to a Network Provider. The amount is the amount charged or the amount Oxford determines to be the reasonable charge, whichever is less, for a particular Covered Service in the geographical area it is performed. Additionally, reimbursement is subject to all applicable Copayments as similar services provided by a Network Provider.

Mental Health Care and Substance Use Services

A. Mental Health Care Services.

Inpatient Services. The Plan Covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this SPD. Coverage for inpatient services for mental health care is limited to Facilities such as:

- A psychiatric center or inpatient Facility;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care.

The Plan also Covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities and to residential treatment facilities that are licensed or certified under applicable law.

Outpatient Services. The Plan Covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to applicable law or are operated by the Office of Mental Health and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage. The Plan does not Cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth; or
- Services solely because they are ordered by a court.

B. Substance Use Services.

Inpatient Services. The Plan Covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to those Facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also Covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is to those Facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services. The Plan Covers outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such Coverage is limited to Facilities to those that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also Covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member 1) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and 2) is covered under the same Plan that covers the person receiving, or in need of, treatment for substance use, and/or dependency. Plan payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION 6: EXCLUSIONS AND LIMITATIONS

Unless coverage is specifically provided under this SPD or provided under a rider or attachment to this SPD, the following services and benefits are not Covered.

1. Services which are not Medically Necessary. If there is a dispute between a Provider and Oxford about the Medical Necessity of a service or supply, you or your Provider may appeal Oxford's decision. Any disputed service or supply will not be Covered during the appeal process.
2. Acupuncture therapy.
3. Unless added to this SPD, Alcohol and Substance Abuse Services on an inpatient basis and detoxification are not Covered.
4. An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.
5. Blood, blood plasma and blood derivatives other than those described as Covered Services. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not Covered.
6. Care for conditions that by federal, state or local law must be treated in a public facility

including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

7. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
8. Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.
9. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if Oxford agrees that the services are Medically Necessary, are otherwise Covered, the Participant has not exhausted their benefit for the contract/calendar year, and the treatment is provided in accordance with our policies and procedures.
10. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The Plan does not Cover room, board, nursing care or personal care which is rendered to assist a Participant who, in Oxford's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
11. Services in connection with elective cosmetic surgery. The Plan does not cover cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such services is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent which has resulted in a functional defect.
12. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, and treatment of periodontal disease or orthognathic surgery. As described in "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.
13. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional; membership in health clubs, diet plans or clubs even if recommended by a Physician or any other provider for purpose of losing weight; any counseling or

courses in diabetes management other than as described as Covered under this SPD; stays at special facilities or spas for the purpose of diabetes education/management; special foods, diet aids and supplements related to dieting.

14. Durable Medical Equipment (other than as specifically Covered under this SPD. The Plan also does not Cover: TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.
15. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required but has not been granted. Oxford will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Oxford's Medical Advisory Board and provided in accordance with the provisions of this SPD. Under no circumstances will the Plan Cover autologous bone marrow transplants combined with high dose chemotherapy except, when medically appropriate, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Oxford's Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by Oxford's Medical Advisory Board and provided in accordance with the provisions of this SPD. The Plan does not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, The Plan will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Oxford's denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials the Plan will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the SPD for non-investigational treatments.
16. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that Oxford determines were not Emergencies, when received in an emergency room, are not Covered.
17. Infertility treatments and supplies (except as otherwise Covered under this SPD), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered: cost for an ovum donor or donor sperm, sperm storage costs, chromosomal analyses, testicular biopsy, elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles, radiographic imaging to determine tubal patency; blood analyses related to immunological diagnosis of infertility, cryopreservation and storage of embryos (unless the Participant has not yet reached her lifetime limit of four egg retrievals), in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy and all costs for and relating to surrogate motherhood (maternity services are Covered for Participants acting as surrogate mothers). The Plan also does not Cover services to reverse voluntary sterilization. Treatment of an underlying medical condition will not be denied (if the treatment is

otherwise covered under the SPD) solely because the medical condition results in infertility.

18. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. The Plan also does not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.
19. Services and treatment provided in a government facility, i.e., military services-related injuries.
20. No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance.
21. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
22. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this SPD.
23. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.
24. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Participant's rights have been waived or qualified.
25. Outpatient Prescription Drugs.
26. Private or special duty nursing.
27. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.
28. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.
29. Services for which the day or visit limit identified in the *Plan Highlights* has been met.
30. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Associate.
31. Services, solely because such services are ordered by a court.

32. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.
33. Sex Transformations. Any procedure or treatment designed to alter the physical characteristics of a Participant from the Participant's biological sex to those of the opposite sex regardless of any diagnosis of gender role or psychosexual orientation problems.
34. Special foods and diets, supplements, vitamins and enteral feedings, except as what is otherwise outlined in this SPD. When coverage of special foods, diets and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered.
35. Special medical reports not directly related to treatment. Appearances in court or at a hearing.
36. Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are Covered if Preauthorized and approved by Oxford's Medical Director.
37. Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.
38. Transplant services required by a Participant when the Participant serves as an organ donor are not Covered unless the recipient is a Participant. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. The Plan does not Cover travel expenses, lodging, meals or other accommodations for donors or guests. Transplants performed in facilities other than those designated by Oxford for the transplant procedure are not Covered.
39. Treatment provided in connection with services for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.
40. Coverage outside of the United States. No coverage is available outside of the United States if the Participant traveled out of-the-country to obtain medical treatment, drugs or supplies. Additionally, the Plan will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

When a Participant is traveling for other purposes, only Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions)

41. Unnecessary Care. In general, the Plan will not Cover any health care service that in Oxford's sole judgment, determines is not Medically Necessary. If an external appeal agent certified by the State overturns Oxford's denial, however, the Plan shall Cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise Covered under the terms of this SPD.
42. Eyeglasses and examination for the prescription of fitting thereof, unless added through supplemental coverage.
43. Wigs, or any other appliance or procedure related to hair loss regardless of the disease or injury causing the hair loss (except following chemotherapy).
44. Weight Control. All services, supplies, programs and surgical procedures for the purpose of weight control.
45. Any service, supply or treatment not specifically listed in this SPD as a Covered Service, supply or treatment. Any supply or treatment for which the Participant has no legal obligation to reimburse the Provider. Any supply or treatment provided by a Participant of the Participant's family (mother, step-mother, father, stepfather, sister, step-sister, brother, step-brother, any "in-law," aunt, uncle, niece, nephew or cousin).

SECTION 7: PARTICIPANT RIGHTS AND RESPONSIBILITIES

What Are My Rights as a Participant?

As a Participant you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

You have the right to receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

You also have the right to refuse treatment to the extent permitted by law. Oxford and your PCP will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and Oxford and your Network Provider believe no professionally acceptable alternative exists, Oxford will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

If a Participant is not capable of understanding any of this information, an explanation will be

provided to his or her guardian, designee or a family Participant.

2. The right to be provided with information about Oxford's services, policies, procedures, grievance and appeal procedures and Oxford's Network Providers that accurately provides relevant information in a manner that is easily understood.
3. The right to quality health care services, provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.
4. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.
5. The right to initiate disenrollment from the Plan.
6. The right to file a formal grievance or appeal if complaints or concerns arise about Oxford's medical or administrative services or policies.
7. The right, when Medically Necessary, to emergency care without unnecessary delay.
8. The right to be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.
9. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your provider.

What Are My Responsibilities?

Your Responsibilities Include:

1. To enter into this Plan with the intent of following the policies and procedures as outlined in this SPD.
2. To take an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.
3. To provide, to the extent possible, information that professional staff need in order to care for you as a Participant.
4. To use the emergency room only as described in this SPD.
5. To notify the proper Plan representative of any change in name, address or any other important information.

SECTION 8: CLAIMS PROCEDURES

What this section includes:

- How Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Services from a Network provider, Oxford will pay the Physician or facility directly. If a Network provider bills you for any Covered Service other than your Copay or Coinsurance, please contact the provider or call the Customer Service phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of this SPD, coverage will be provided as described in this SPD.

How to Submit A Claim

You can obtain a claim form by visiting www.oxhp.com, calling the toll-free Customer Service number on your ID card or contacting your Plan Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the Sickness or Injury began; and
 - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with Oxford at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the a Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

Limitations

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request.

If You Receive a Bill From a Network Provider

The cost of Covered Services provided by Network Providers in accordance with the terms of this SPD will be billed directly to Oxford. **No claim forms are necessary.**

If you should receive a bill from a Network Provider for Covered Services, please contact the Customer Service Department immediately.

Claim Information

Please allow up to 30 business days for the processing of Network claims.

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this SPD. Please have the date of service and your ID number ready.

Explanation of Benefits (EOB)

You may request that Oxford send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you

would like paper copies of the EOBs, you may call the toll-free Customer Service number on your ID card to request them. You can also view and print all of your EOBs online www.oxhp.com.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Oxford at the number on your ID card before requesting a formal appeal. If Oxford cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

Oxford – Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your Provider can call Oxford at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or

- concurrent claim.

Review of an Appeal

Oxford will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Oxford upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Oxford within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Oxford will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Oxford, or if Oxford fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Oxford's determination. The process is available at no charge to you. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Oxford's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;

- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Oxford has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by Oxford of the request;
- a referral of the request by Oxford to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, Oxford will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the preliminary review, Oxford will issue a notification in writing to you. If the request is eligible for external review, Oxford will assign an IRO to conduct such review. Oxford will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Oxford will provide to the assigned IRO the documents and information considered in making Oxford's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Oxford; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include

this information with your external review request and Oxford will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Oxford, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Oxford determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Oxford will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the review, Oxford will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Oxford will assign an IRO in the same manner Oxford utilizes to assign standard external reviews to IROs. Oxford will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the

IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Oxford.

You may contact Oxford at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits- a request for Benefits provided in connection with Urgent Care services, as defined in Section 13, Glossary;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and Oxford are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, Oxford must notify you within:	24 hours
You must then provide completed request for Benefits to Oxford within:	48 hours after receiving notice of additional information required
Oxford must notify you of the benefit determination within:	72 hours
If Oxford denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call Oxford as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, Oxford must notify you within:	5 days
If your request for Benefits is incomplete, Oxford must notify you within:	15 days
You must then provide completed request for Benefits information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	15 days
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, Oxford must notify you within:	30 days
You must then provide completed claim information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Post-Service Claims	
Type of Claim or Appeal	Timing
Oxford must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Oxford will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against St. John’s University or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against St. John’s University or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against St. John’s University or the Claims Administrator.

You cannot bring any legal action against St. John’s University or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against St. John’s University or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against St. John’s University or the Claims Administrator.

Employee Retirement Income Security Act (ERISA) Rights:

After all levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if the Participant’s coverage for health benefits was:

1. Obtained through employment with a church or government group; or

2. Purchased as an individual plan from Oxford.

SECTION 9: COORDINATION OF BENEFITS

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Please note: This Plan does not coordinate benefits with itself.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary it determines the amount it will pay for a Covered Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare. Please note that this applies even if the Participant fails to enroll in Medicare or does not claim Benefits available under Medicare.

There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Oxford may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Oxford does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Oxford any facts needed to apply those rules and determine benefits payable. If you do not provide Oxford the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, St. John's University may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, Oxford reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If St. John's University pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to St. John's University if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment St. John's University made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount St. John's University paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help St. John's University get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, St. John's University may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. St. John's University may have other rights in addition to the right to reduce future Benefits.

SECTION 10: SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the

Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- St. John's University in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
 - underinsured or uninsured motorist insurance;
 - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
 - workers' compensation coverage; or
 - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
 - complying with the terms of this section;
 - providing any relevant information requested;
 - signing and/or delivering documents at its request;
 - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - responding to requests for information about any accident or injuries;
 - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
 - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- no allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms

of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 11: WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, St. John's University will still pay claims for Covered Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. When a Participant loses eligibility, his or her Dependents will also become ineligible on that date.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date the Claims Administrator receives written notice from St. John's University to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date the Claims Administrator receives written notice from St. John's University to end your coverage, or the date requested in the notice, if later;
- the date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent; or

Note: If the Claims Administrator and St. John's University find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact St. John's University has the right to demand that you pay back all Benefits St. John's University paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to St. John's University proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon St. John's University's request, that the child continues to meet these conditions.

The proof might include medical examinations at St. John's University's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in the *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if St. John's University is subject to the provisions of COBRA.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
St. John's University files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage. How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment Period; and
- following a change in family status, as described under *Changing Your Coverage*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in *Important Administrative Information: ERISA* section. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium is not paid within 45 days;
- the date coverage ends for failure to make any other monthly premium is not paid within 30 days of its due date;
- the date the entire Plan ends; or

- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Other Available Coverage

Leave of Absence or Layoff

If your coverage would terminate because you are temporarily laid off or receive an approved leave of absence, coverage may be continued for up to 60 days, or as otherwise agreed upon by the Plan Administrator, if the Plan Administrator (1) pays the benefit cost contributions for the continued coverage; and (2) requires all participating carriers to provide continued coverage to employees whose coverage would otherwise terminate because of a temporary layoff or approved leave of absence.

Family and Medical Leave Act

Federal law provides that certain employees can take up to 12 weeks of unpaid leave in a 12-month period for:

- the birth or adoption of a child;
- for a serious health condition affecting the employee or a family Participant
- for any qualifying exigency arising out of the fact that the employee's spouse, child or parent is on or has been called to active duty in the Armed Forces; or
- up to 26 weeks of unpaid leave in a 12-month period to care for an injured service member.

Employers subject to this law are required to keep an employee's medical coverage in force to the same extent as if no leave had been taken. Your obligations, including any contributions and compliance with Plan provisions, do not change during a leave.

If your Employer is subject to this law, and you are eligible for leave under the Act, the Plan will continue your coverage during the qualified leave. Coverage will terminate for failure to comply with Plan provisions, including the failure to pay benefit cost contributions. You should check with your employer regarding family and medical leaves.

SECTION 12: OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with Oxford and St. John's University;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with Oxford and the Plan Administrator

In order to make choices about your health care coverage and treatment, the Plan Administrator believes that it is important for you to understand how Oxford interacts with the Plan Administrator's benefit Plan

and how it may affect you. Oxford helps administer the Plan Sponsor's benefit plan in which you are enrolled. Oxford does not provide medical services or make treatment decisions. This means:

- Your Plan Administrator and Oxford do not decide what care you need or will receive. You and your Physician make those decisions;
- Oxford communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan Administrator and Oxford may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Administrator and Oxford will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Plan Administrator and Oxford will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Plan Administrator, Oxford and Network providers are solely contractual relationships between independent contractors. Network providers are not the Plan Administrator's agents or employees, nor are they agents or employees of Oxford. The Plan Administrator and any of its employees are not agents or employees of Network providers, nor is Oxford and any of its employees agents or employees of Network providers.

The Plan Administrator and Oxford do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan and Oxford arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Oxford's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Plan Administrator's employees nor are they employees of Oxford. The Plan Administrator and Oxford do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan Administrator and Oxford are not liable for any act or omission of any provider.

Oxford is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan Administrator is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

- are responsible for paying, directly to your provider, the cost of any non-Covered Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The Plan Administrator and Oxford have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The Plan Administrator and Oxford may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator may, in its discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require the Plan Administrator to do so in other similar cases.

Information and Records

Your medical records are confidential documents. St. John's University and Oxford may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. St. John's University and Oxford may request additional information from you to decide your claim for Benefits. St. John's University and Oxford will keep this information confidential. St. John's University and Oxford may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish St. John's University and Oxford with all information or copies of records relating to the services provided to you. St. John's University and Oxford have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. St. John's University and Oxford agree that such information and records will be considered confidential.

St. John's University and Oxford have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as St. John's University is required to do by law or regulation. During and after the term of the Plan, St. John's University and Oxford and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements St. John's University recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Oxford, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, St. John's University and Oxford will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Oxford's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but St. John's University recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

St. John's University and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. St. John's University and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation

Injuries and diseases covered under any Workers' Compensation program are excluded from coverage under this Plan.

Future of the Plan

Although St. John's University expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If St. John's University does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to St. John's University and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 13: GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Applied Behavior Analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Acute – The sudden onset of disease or injury, or a sudden change in the Participant's condition that would require prompt medical attention.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Ambulatory Surgical Centers - A facility currently licensed by the appropriate state regulatory agency for the provisions of surgical and related medical services on an outpatient basis.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Services in a calendar year before the Plan will begin paying Benefits in that calendar year.

Autism Spectrum Disorder - any pervasive developmental disorders set forth in the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*,

including but not limited to Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Benefits – Plan payments for Covered Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Claims Administrator –Oxford and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Services.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Services.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Covered or Covered Services – the Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of this SPD.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to “you” and “your” throughout this SPD are references to a Covered Person.

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements as described in the *Eligibility* Section of this SPD.

Detoxification Facility – a health care facility licensed by the State as a Detoxification Facility for the treatment of alcoholism.

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Services that are provided while the Plan is in effect. For certain Covered Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance. Eligible Expenses are subject to Oxford’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from Oxford.

Enrollment Date – The Enrollment Date is the Participant’s first day of coverage under the SPD or, if earlier, the first day of the waiting period that must pass with respect to the Participant before the Participant is eligible to be covered under the Plan.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – St. John’s University.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Exclusions – what the Plan does not Cover as a Covered Service.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug

therapies, medications or devices that, at the time Oxford makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5, *Covered Services*.
- If you are not a participant in a qualifying Clinical Trial as described under in Section 5, *Covered Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by Oxford to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Grievance – A complaint that You communicate to Oxford that does not involve a Utilization Review determination.

Habilitation Services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a Hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A Hospital may be a general, Acute care, or a specialty institution, provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by Oxford or its designee, within Oxford's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Oxford reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Oxford's sole discretion.

Oxford develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by Oxford and revised from time to time), are available to Covered Persons on www.oxhp.com or by calling the number on your ID card.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Network – when used to describe a provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network.

Network Provider – A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Oxford to provide Covered Services to our Participants. A list of Network Providers and their locations is available to you upon enrollment or upon request. This list will be revised from time to time by Oxford.

Non-Participating Provider – A Provider who doesn't have a contract with the Claims Administrator to provide services to you. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Oxford.

Open Enrollment Period – A period of time, established by the Plan Sponsor, during which eligible persons may be enrolled. Your employer will have the dates for each period.

Out-of-Pocket Maximum – the maximum amount you pay every plan year. Refer to the *Plan Highlights* for the Out-of-Pocket Maximum amount.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility*. A Participant must live and/or work in the United States.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, nurse practitioner, clinical social worker, physician assistant, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The St. John's University Medical Plan.

Plan Administrator – v or its designee.

Plan Sponsor – St. John's University or its designee.

Preauthorization - enables Oxford to review the Medical Necessity of a proposed service or treatment including the determination of a proposed site of care, manage benefit limitations, and whether the service will be performed by a Network Provider. Preauthorization allows Oxford to notify the Participant or the Participant's Provider regarding coverage before the service is provided.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Care Physician – a Network Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a benefit

only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Services - the Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of this SPD.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Summary Plan Description (SPD) – This SPD administered by Oxford Health Plan, including the summary of coverage under *Plan Highlights* and any attached Amendments.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received).
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Oxford has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Oxford issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.oxhp.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), Oxford and St. John's University may, at their discretion, consider an otherwise Unproven Service to be a Covered Service for that Sickness or condition. Prior to such a consideration, Oxford and St. John's University must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Service is solely at Oxford's and St. John's University's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Usual, Customary and Reasonable (UCR) – The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Utilization Review – The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

SECTION 14: IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in the *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

St. John University's is the Plan Sponsor and Plan Administrator of the St. John University's Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
St. John's University
8000 Utopia Parkway
Jamaica, NY 11439

Claims Administrator

Oxford is the Plan's Claims Administrator . The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with St. John University's. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Administrator's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Administrator's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

Oxford Health Plans, LLC
P.O. Box 29139
Hot Springs, AR 71903

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
St. John's University
8000 Utopia Parkway
Jamaica, NY 11439

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	St. John's University Welfare Benefit Plan
Plan Number:	SJ00301
Employer ID:	11-1630830
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and St. John's University
Source of Benefits:	Assets of St. John's University

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800)-998-7542.

The Plan's Benefits are administered by St. John's University, the Plan Administrator. Oxford is the Claims Administrator and processes claims for the Plan and provides appeal services; however, Oxford and St. John's University are not responsible for any decision you or your Dependents make to receive treatment, services or supplies from a provider. Oxford and St. John's University are neither liable nor responsible for the treatment, services or supplies you receive from providers.

ATTACHMENT I– HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act (“PPACA”)

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the Customer Service number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the Customer Service number on the back of your ID card.

ATTACHMENT II - PRESCRIPTION DRUG COVERAGE

The Plan offers Prescription Drug Coverage. Subject to the Exclusions below, the cost of Medically Necessary Prescription Drug Products will be covered by the Plan if they are FDA approved, ordered by a Provider, within the approved FDA administration and dosing guidelines and are dispensed by a Pharmacy. Covered Prescription Drug Products may be subject to any Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums identified on the *Plan Highlights*. Please refer to the *Plan Highlights* to determine your Out-of-Pocket Expenses and whether coverage is available at Out-of-Network Pharmacies.

Covered Prescription Drug Products include, but are not limited to:

- Self-injectable Prescription Drug Products
- Inhalers (with spacers)
- Topical dental preparations
- Pre-natal vitamins, vitamins with fluoride and single entity vitamins
- Prescription osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria
- Non-Prescription enteral formulas for home use for which a Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary as a disease-specific treatment regimen for diseases which include but are not limited to inherited diseases of amino acid or organic acid metabolism; Chron's disease; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Nutritional supplements that are taken electively are not covered.
- Modified solid food products that are low in protein or which contain modified protein are covered, when Medically Necessary, to treat certain inherited diseases of amino acid and organic acid metabolism not to exceed the maximum listed in the *Plan Highlights*.
- Prescription Drug Products for the treatment of correctible medical conditions which result in infertility will be covered at the same level as benefits for any other sickness.

Refills of Prescription Drug Products are covered only when dispensed as ordered by a Provider and only after $\frac{3}{4}$ of the original Prescription Drug Product has been used.

Section 2 – Benefit Information

1. **Out-of-Pocket Expenses:** You are responsible for paying the costs outlined in the *Plan Highlights* when covered Prescription Drug Products are obtained from the retail pharmacy or mail order supplier (if mail order coverage has been purchased). Please refer to the *Plan Highlights* to determine if your Plan includes coverage for mail order.

Unless otherwise stated in the *Plan Highlights*, these costs will not be included in calculating the Plan Out-of-Pocket Maximum.

You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-covered drug product.

2. **Network Pharmacies:** For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:
 - the applicable Out-of-Pocket Expense; or
 - the Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product.

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by Oxford during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy. You may seek reimbursement from Oxford, however when you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Out-of-Pocket Expense identified on the *Plan Highlights*.

In the event that no Network Pharmacy is able to provide the covered Prescription Drug Product, and cannot order the Prescription Drug Product within a reasonable time you may, with Oxford's prior written approval, go to an Out-of-Network Pharmacy that is able to provide the Prescription Drug Product. Oxford will pay you the Prescription Drug Cost for such approved Prescription Drug Product less the required Out-of-Pocket Expense upon receipt of a Prescription Drug Claim form.

3. **Out-of-Network Pharmacies:** If your Plan includes coverage for Prescription Drug Products purchased at a retail Out-of-Network Pharmacy you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with Oxford. The Plan will not reimburse you for the difference between the Prescription Drug Cost and the Out-of-Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. In most cases you will pay more if you obtain Prescription Drug Products from an Out-of-Network. Please refer to the *Plan Highlights* to determine if you have coverage at an Out-of-Network Pharmacy.
4. **Tier Status:** The tier status of a Prescription Drug Product may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on the PDL Management Committee's periodic tiering decisions. When such changes occur, your Out-of-Pocket Expense may change. You may access the most up to date tier status on Oxford's web site or by calling the Customer Service number on your ID card.
5. **Supply Limits:** Benefits for Prescription Drug Products are subject to the supply limits that are stated in the *Plan Highlights*. Some Prescription Drug Products may be subject to quantity limits based on criteria that Oxford has developed, subject to Oxford's 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.

Additionally, certain Prescription Drug Products may be designated as eligible for Oxford's voluntary half-tablet program. This program provides the opportunity to reduce your Prescription Drug Product Out-of-Pocket Expenses by up to 50% by using higher strength tablets and splitting them in half. If you are taking an eligible Prescription Drug Product, and you would like to participate in this program, please call your Provider to see if the half tablet program is appropriate for your condition. If your Provider agrees, he or she must write a new prescription for your medication to enable your participation.

You can determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing or is eligible for the voluntary half tablet program by accessing Oxford's web site or by calling Customer Service at the telephone number on your ID card.

7. **Mail Order:** Certain Prescription Drug Products may be ordered through Oxford's mail order supplier if your Plan has purchased this coverage. If your Plan has purchased mail order coverage, you are responsible for paying the lower of:
 - the applicable Out-of-Pocket Expense; or
 - the Prescription Drug Cost for that Prescription Drug Product.

Prescription Drug Products purchased through mail order will be delivered directly to your home or office. You must pay the applicable Out-of-Pocket Expense listed in the *Plan Highlights*. The required Out-of-Pocket Expense will be based on a 90-day supply. To maximize your benefit, ask your Provider to write your Prescription Order or Refill for a 90-day supply with refills when appropriate. You will be charged the mail order Out-of-Pocket Expense for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill. Be sure your Provider writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Please refer to the *Plan Highlights* to determine if your Plan includes coverage for mail order.

8. **When a Brand-Name Drug Becomes Available as a Generic:** When a Generic becomes available for a Brand-Name Prescription Drug Product, the tier placement of the Brand Name Prescription Drug Product may change. If this happens, you will pay the Out-of-Pocket Expense applicable for the tier to which the Prescription Drug Product is assigned as outlined in the *Plan Highlights*.

Section 3 – Terms of Coverage

1. **Tier Structure:** Oxford's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on Oxford's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors, including, but not limited to, clinical and economic factors regarding Participants as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Participant is a determination that is made by the Participant and the prescribing Provider. Clinical factors may include, but are not limited to, evaluation of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or Preauthorization requirements should apply. Economic factors may include, but are not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

The tier status of a Prescription Drug Product may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on the PDL Management Committee's periodic tiering decisions. These changes may occur without prior notice to you. As a result of such changes you may be required to pay more or less for that Prescription Drug Product. Please access Oxford's web site or call the Customer Service number on your ID card for the most up to date tier status.

2. **Preauthorization:** Certain Prescription Drug Products will be covered in accordance with Oxford's applicable Medical Policy if they are determined by Oxford to be Medically Necessary for their intended use as evidenced by the **advance written approval of Oxford's Medical Director**. The Prescription Drug Products that require Preauthorization are listed on the attachment titled "Prescription Drug Products Requiring Preauthorization". This information is also available through the Internet at www.oxhp.com or by calling Customer Care at the telephone number on your ID card.

Oxford also reserves the right to require Preauthorization for any new drug on the market or of any currently available drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification.

In addition, certain Prescription Drug Products may be designated as Step Therapy Drugs. This means that before coverage for such Prescription Drug Product will be provided, you must have tried one or more “prerequisite” Prescription Drug Products. If it is Medically Necessary for you to use a Step Therapy Drug as an initial medication, your Provider can request initial coverage as a medical exception. Confirmation of whether a drug is a Step Therapy Drug can be obtained through Oxford’s web site or by calling Customer Service at the number on your ID card.

To initiate the Preauthorization process, your Provider must contact Oxford and provide all relevant clinical data. If Preauthorization has been granted you will be responsible for the applicable Out-of-Pocket Expense listed in the *Plan Highlights*. Should you choose to purchase the medication without obtaining Preauthorization, you must pay for the cost of the entire drug and submit a claim to Oxford for reimbursement. **Claims for reimbursement of such drugs will be subject to a Preauthorization penalty of 50%.**

3. **Limitation on Selection of Pharmacies:** If Oxford determines that you may be using a Prescription Drug Product in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, Oxford may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don’t make a selection within 31 days of the date Oxford notifies you, Oxford will select a single Network Pharmacy for you.
4. **Rebates and Other Payments to Oxford:** Oxford 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, your Plan and its members benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. Oxford may, from time to time, also enter into agreements that result in Oxford receiving rebates or other funds (“rebates”) directly or indirectly from prescription drug manufacturers, prescription drug distributors or others. Any rebates are based upon utilization of Prescription Drug Products across all of Oxford’s business and not solely on any on Participant’s or Plan’s utilization of Prescription Drug Products.

Any rebates received by Oxford may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Oxford’s prescription drug premiums. Any such rebates may instead be retained by Oxford, at Oxford’s discretion, in whole or in part, in order to fund such activities, including but not limited to, as new utilization management activities, community benefit activities and increasing reserves for the protection of subscribers. Rebates will not change or reduce the amount of any Out-of-Pocket Expenses applicable under Oxford’s prescription drug coverage.

Section 4 – Exclusions

In addition to the Exclusions listed in your SPD, the following are excluded from coverage under this Plan:

1. Prescription Drug Products obtained from an Out-of-Network Pharmacy, unless your Plan has purchased such coverage. Please refer to the *Plan Highlights* to see if your Plan has purchased Out-of-Network coverage for Prescription Drug Products.
2. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) which exceeds the supply limit. Any prescription refilled in excess of the number specified by the Provider; refilled too soon or in excess of therapeutic limits; or any refill dispensed after one year from the Provider’s original order.

3. Prescription Drug Products dispensed outside of the United States, including its possessions or the countries of Canada and Mexico, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental or Investigational Services and medications; medications used for experimental indications and/or dosage regimens determined by Oxford to be experimental, investigational or unproven unless approved by an external appeal agent. Please see the “Utilization Review Appeal” Section of your SPD for your appeal rights.

Important: If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Oxford will only Cover the cost of services required to provide treatment to you according to the design of the trial. Oxford will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this SPD for non-experimental or non-investigational treatments provided in such clinical trial.

This exclusion does not apply to drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration for that indication, if the drug has been prescribed for a Participant who has been diagnosed with cancer, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (i) the American Medical Association Drug Evaluations; (ii) the American Hospital Formulary Service Drug Information; or (iii) the United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal. This exception does not provide coverage for any experimental or investigational drugs or any drug which the Federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are provided under any Workers’ Compensation Law or other similar laws.
8. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics, as determined by Oxford, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than inhaler spacers and drugs for the treatment of osteoporosis specifically stated as covered.
10. Unit dose packaging of Prescription Drug Products.
11. Prescription Drug Products used for cosmetic purposes. Please note, all denials for these items are based on Medical Necessity. If coverage is denied, you are entitled to a Utilization Review Appeal.
12. Prescription Drug Products, including new Prescription Drug Products or new dosage forms that are determined to not be a covered service.

13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, misused, stolen, broken or destroyed.
14. Diabetic Equipment and Supplies. Coverage for diabetic equipment and supplies is provided as part of your medical benefits. Please refer to your SPD for an explanation of these benefits.
15. Non-FDA approved legend drugs, non-legend drugs and drugs available over-the-counter which do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug unless Medically Necessary. Prescription Drug Products that are comprised of components available in Over-the-Counter form or equivalent.
16. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill will be assigned to either Tier 2 or Tier 3.
17. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the PDL Management Committee unless Medically Necessary.
18. Vitamins, hematinics, minerals and supplements, even if ordered by a Provider, unless specifically listed in the covered Items section of this Rider.
19. Charges for the administration or injection of any drug.
20. Immunization agents, biological sera, blood or blood plasma.
21. Allergens and allergy serums.
22. Oral and topical prescription antiseptics.
23. Prescription weight loss aids other than those used for the treatment of morbid obesity. Weight loss drugs that are used in the treatment of morbid obesity are automatically covered under the Prescription Drug Plan. Please note, all denials for these items are based on Medical Necessity. If coverage is denied, you are entitled to a Utilization Review Appeal.
24. Prescription Drug Products for smoking cessation. Please note, all denials for these items are based on Medical Necessity. If coverage is denied, you are entitled to a Utilization Review Appeal.

Section 5 – Definitions

This section defines the terms used throughout this rider. Other defined terms used in this rider can be found in the Definitions Section of your SPD. This section is not intended to describe benefits.

Brand-Name: a Prescription Drug Product that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that Oxford identifies as a Brand-Name Product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a “brand name” by the manufacturer, pharmacy, or your Provider may not be classified as Brand-Name by Oxford.

Generic: a Prescription Drug Product that (1) is chemically equivalent to a Brand-Name drug; or (2) that Oxford identifies as a Generic product based on available data resources including, but not limited to,

First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a “generic” by the manufacturer, pharmacy, or your Provider may not be classified as a Generic by Oxford.

Network Pharmacy: a pharmacy that has:

- entered into an agreement with Oxford or our designee to provide Prescription Drug Products to Participants;
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- has been designated by Oxford as a Network Pharmacy.

A Network Pharmacy can be either a retail or home delivery pharmacy for Plans that include coverage for mail order. Please refer to the *Plan Highlights* to determine if your Plan includes coverage for mail order.

New Prescription Drug Product: a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- the date it is assigned to a tier by our PDL Management Committee; or
- December 31st of the following calendar year.

Prescription Drug Cost: the rate Oxford has agreed to pay Oxford’s Network Pharmacies, including a dispensing fee and any sales tax, for a covered Prescription Drug Product dispensed at a Network Pharmacy. If your Plan includes coverage at Out-of-Network Pharmacies, the Prescription Drug Cost for a Prescription Drug Product dispensed at an Out-of-Network Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug List (PDL): the list that identifies those Prescription Drug Products for which Coverage may be available under this rider. This list is subject to Oxford’s periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through Oxford’s web site or by calling the Customer Service number on your ID card.

PDL Management Committee: the committee that Oxford designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

Prescription Drug Product does not include medical supplies, drugs, medications, injections or intravenous therapies (i) provided at a hospital; (ii) provided in connection with any home care benefit under the SPD; or (iii) that must be administered by a physician or physician-supervised health professional.

Prescription Order or Refill: the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge: the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

ATTACHMENT III – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification or prior authorization. For information on precertification or prior authorization, contact your issuer.