

Genesee Area Healthcare Plan

PPO Benefit Booklet

PLAN DESCRIPTION

PLAN ADMINISTRATOR: GENESEE AREA HEALTHCARE PLAN
c/o Genesee Valley BOCES
80 Munson Street
LeRoy, NY 14482

TYPE OF PLAN: Medical, Dental, Vision and Prescription Drug

AGENT FOR SERVICE OF LEGAL PROCESS: GENESEE AREA HEALTHCARE PLAN

PLAN NUMBER: 501

PLAN YEAR: July 1 through June 30

PLAN REVISION DATE: July 1, 2003

FUNDING AND ADMINISTRATION: The Plan is funded by direct benefit payments by the Participating Schools for claims having been paid on behalf of the Participating Schools by:

Excellus BlueCross BlueShield, Rochester Region
165 Court Street
Rochester, NY 14647
585-325-3630
Toll-Free (800) 847-1200

Preferred Provider Organization (PPO)

Who is a Preferred In-Network Provider:

A group of hospitals, physicians and ancillary providers that contract on a fee-for-service basis to provide comprehensive medical service.

You can choose any provider as needed. Levels of coverage are higher and your out-of-pocket expenses are lower if you use participating network providers.

Benefit Summary for Genesee Area Healthcare Plan

<u>Services</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>HOSPITAL- INPATIENT SERVICES</u>		
Hospital Services	Unlimited days in semi-private accommodations and all medically necessary services for acute care covered at 100%.	Unlimited days in semi-private accommodations and all medically necessary services for acute care covered at 80%, subject to the deductible.
Skilled Nursing Facility	Unlimited days in semi-private accommodations and all necessary services are covered at 100%. Custodial care is not covered.	Unlimited days in semi-private accommodations and all necessary services are covered at 80%, subject to the deductible. Custodial care is not covered.
Hospice	Covered at 100%.	Covered at 80%, subject to the deductible.
<u>HOSPITAL OUTPATIENT SERVICES</u>		
Diagnostic X-Ray	Covered at 100%.	Covered at 80%, subject to the deductible.
Diagnostic Laboratory and Pathology	Covered at 100%.	Covered at 80%, subject to the deductible.
Chemotherapy	Covered at 100%.	Covered at 80%, subject to the deductible.
Radiation Therapy	Covered at 100%.	Covered at 80%, subject to the deductible.
Surgical Care	Covered at 100%.	Covered at 80%, subject to the deductible.
Pre-admission Testing	Covered at 100%.	Covered at 80%, subject to the deductible.
<u>EMERGENCY SERVICES</u>		
Life Threatening and Urgent Medical Emergencies	Emergency Room - \$50 copayment per visit unless admitted as an inpatient to the hospital.	Emergency Room covered at 80%, subject to the deductible.

<u>Services</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>PHYSICIAN'S SERVICES</u>		
<u>Hospital Inpatient</u>		
Physician Visits	Unlimited days covered at 100%.	Unlimited days covered at 80%, subject to the deductible.
Surgery	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Anesthesia	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
<u>Physician's Office</u>		
Diagnostic Office Visits	\$10 charge per visit.	Covered at 80% of allowed charges, subject to the deductible.
Routine Preventive Services	<p>One routine physical covered per calendar year, \$10 charge per visit. Annual GYN exam and Pap Smear for women aged 18 and over covered at \$10 charge per visit.</p> <p>Covering one routine cholesterol and one PSA lab, and related lab work per calendar year as part of a routine physical.</p> <p>Periodic well child visits, immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics recommended schedule.</p>	<p>No coverage for routine physical exams.</p> <p>Annual GYN exam and Pap Smear for women aged 18 and over covered at 80% of allowed charges, subject to the deductible.</p> <p>Periodic well child visits, immunizations, laboratory and other services ordered at the time of the visit covered at 100%, according to the American Academy of Pediatrics recommended schedule.</p>
Allergy Tests	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Allergy Injections	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Eye Exams	No coverage for routine eye exams or refractions. Diagnostic (related to disease or injury), \$10 charge per visit.	No coverage for routine eye exams or refractions. Diagnostic (related to disease or injury) covered at 80% of allowed charges, subject to the deductible.
Chemotherapy	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Radiation Therapy	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Diagnostic Laboratory and Pathology	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Diagnostic X-ray	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.

<u>Services</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>MATERNITY</u>		
Hospital Charges for Mother	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Physician Charges for Mother	Covered at 100%.	Covered at 80%, subject to the deductible.
Newborn Nursery Care	Covered at 100%. The initial and one subsequent examination when performed by a physician between the date of birth and the newborn's discharge from the hospital covered at 100%.	Covered at 80%, <i>not</i> subject to the deductible. The initial and one subsequent examination when performed by a physician between the date of birth and the newborn's discharge from the hospital covered at 80%.
<u>PSYCHIATRIC AND CHEMICAL DEPENDENCY</u>		
<u>Inpatient</u>		
Acute Psychiatric	Precertification required Up to 30 days per member per calendar year, covered at 100%. Combined benefit with Chemical Dependency.	Precertification required Up to 30 days per member per calendar year covered at 80%, subject to the deductible. Combined benefit with Chemical Dependency.
Chemical Dependency	Up to 30 days per member per calendar year, covered at 100%. Combined benefit with Acute Psychiatric.	Up to 30 days per member per calendar year covered at 80%, subject to the deductible. Combined benefit with Acute Psychiatric.
<u>Outpatient</u>		
Acute Psychiatric	Covered in full for the first \$500. Balance in excess of \$500, covered at 80%, up to 20 visits per member per year. 20 visits is a combined maximum with the out-of-network benefit.	Covered at 50%, subject to the deductible, up to 20 visits per member, per year. 20 visits is a combined maximum with the in-network benefit.
Chemical Dependency	60 outpatient facility visits per member per year covered at 100%. Additional services covered at 80%. 60 visits are a combined benefit with out-of-network. 20 additional days for family counseling.	60 outpatient facility visits per member per year covered at 80%, subject to deductible. Additional services covered at 50%. 60 visits are a combined benefit with in-network. 20 additional days for family counseling.
<u>OTHER SERVICES</u>		
<u>Home Care</u>		
Home Care	Precertification Required Covered at 100%.	Precertification Required Covered at 80% of allowed charges, subject to the deductible.
Physical Therapy	\$10 charge per visit.	Covered at 80% of allowed charges, subject to the deductible.
Speech Therapy	\$10 charge per visit.	Covered at 80% of allowed charges, subject to the deductible.

<u>Services</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Occupational Therapy	\$10 charge per visit.	Covered at 80% of allowed charges, subject to the deductible.
Durable Medical Equipment	Covered at 100%.	Covered at 80% of reasonable and customary charge, subject to the deductible.
Internal Prosthetics	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
External Prosthetics and Orthopedic Braces and Supports	Covered at 100%.	Covered at 80% of allowed charges, subject to the deductible.
Chiropractic Services	\$10 charge per visit.	Covered at 80% of allowed charges, subject to the deductible.
Ambulance	First \$250 paid in full-balance at 80%.	First \$250 paid in full-balance at 80%.
Dental	Covered at 100% when related to an accidental injury to sound, natural teeth and services are rendered within 365 days of the accident. Balances after dental for the surgical removal of impacted teeth and all associated services, covered at 100%.	Covered at 80%, subject to the deductible, when related to an accidental injury to sound, natural teeth and services are rendered within 365 days of the accident. Balances after dental for the surgical removal of impacted teeth and all associated services, covered at 100%.
Supplemental Accident	Maximum benefit of \$300 within 90 days of accident.	No benefit available
Prescription Drugs	Administered by AdvancePCS	Administered by AdvancePCS
Out-of-Area Coverage	Coverage provided worldwide.	Coverage provided worldwide.
Dependent Coverage	Dependents to age 19; unmarried children up to age 26 may be covered if they are registered students in regular full-time attendance at an accredited school.	Dependents to age 19; unmarried children up to age 26 may be covered if they are registered students in regular full-time attendance at an accredited school.
Deductible, Coinsurance and Annual Out of Pocket Maximum	No annual deductible. No coinsurance, unless noted. \$10 copayment.	Calendar year deductible of \$250 per member, \$750 family maximum. Plan then pays 80% unless otherwise noted, of covered services until your deductible and copayment total \$2,000 per member, (excluding benefits paid at 50%). Then plan pays 100% for covered services for the remainder of the calendar year.
Lifetime Benefit Maximum	None.	None.
Plan Year	July 1 - June 30	July 1 - June 30

This Is Not A Contract. It Is Intended To Highlight The Coverage Of This Program. Benefits Are Determined By The Terms Of The Contract. All Benefits Are Subject To Medical Necessity unless otherwise specified.

GENERAL PROVISIONS OF YOUR CONTRACT

Group Contract year- July 1 - June 30

Open Enrollment Period

Open enrollment is held annually during the month of June for an effective date of July 1.

Other than qualifying events (marriage, birth, etc.) all changes to your policy must be made during this time period.

Participants are required to remain in a rider for a minimum of two years, as long as they continue with the Genesee Area Healthcare Plan.

Your Identification card

Your identification card lists your subscriber identification number.

If you have family coverage, your dependents must also use your identification number.

Carry your card at all times. Present it to hospitals, physicians and other health-care providers when you receive care.

In case of loss, contact the Express Line at **(585) 454-5010 or toll free 1-800-847-1200**

ELIGIBILITY

Active Participants

All active participants who are eligible to enroll in the group health plan of a participating school district are eligible for this plan. If a participant is not at work on the effective date of coverage, such coverage will be delayed for the participant and his/her dependents until the participant returns to work.

For participants covered before May 1, 1988, any package of coverages selected by the participant will remain in effect, as an exception only to plan eligibility parameters.

The following parameters apply to active participants:

1. New participants have 30 days from date of hire to select coverages.
2. Participants must choose from coverages sponsored by the School District on the plan anniversary date, July 1.

Retired Participants

A participating school district may allow its retired participants to select any package of coverages as long as each retired participant selects the medical coverage as the base benefit package. The retired participant may select any package of coverages in addition to the medical coverage as long as the coverages are offered to all participants in his/her bargaining unit.

The following parameters apply to retired participants.

1. A retired participant may elect to continue coverage in the plan on or before his/her effective date of retirement.
2. **The participant must have had Genesee Area Healthcare coverage for no less than 12 full months before retirement in order to continue coverage.**
3. **An employee of a participating district, who has Genesee Area Healthcare coverage at or after retirement and drops his/her coverage, may return under the following conditions:**
 - The retired employee must experience one of the following change in family status qualifying events:
 - Divorce of participant
 - Death of participant's spouse
 - Taking of an unpaid leave of absence by spouse
 - Termination of health insurance benefits

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- The qualifying event must occur on or after March 1, 1997, the effective date of this clarification.
 - The retired employee must notify the plan of his/her desire to re-enter the plan within 60 days of the qualifying event.

4. If a retired participant should die, a surviving spouse will have 60 days from the date of the death to elect continuing coverage under the plan. Non-election by the surviving spouse will render him/her ineligible to re-enter the plan at a later date.

Participant

A person employed on a regular full-time or part-time basis by a participating school.

This Plan also covers eligible retirees. Retirees status can be based on the following:

- Disability;
- N.Y. State Retirement System.

This Plan also covers anyone required by law, such as active Board members covered by Municipal Law.

Dependent

1. The wife or husband, unless legally separated.
2. Unmarried children, to age 19, who are principally dependent upon the employee for maintenance and support, and who are not covered under any group plan as an employee.
3. Unmarried children to age 26 who are enrolled as full time students at an accredited institution of learning and whose principal residence, when not away at school, is the same as their parents and who are principally dependent upon the employee for maintenance and support.
 - Regardless of the event, if a dependent child experiences an event that terminates coverage, it will become effective on 12/31 of that year.
 - This applies to those not in college who turn 19, those graduating from, or leaving college, and those still in college who turn 26. If any of these events occur, the dependent is covered through 12/31 of that year.
 - A census form will be distributed each September to participants who have dependents between the ages of 19 and 26 on their policy, to determine their status. Appropriate documentation of the dependent's full-time status will be required to accompany the census form.
 - All students must be dependents of their parents to be covered.
4. A child who is mentally or physically incapable of earning his own living may be continued as a dependent, provided proof of the child's incapacity is submitted.

The term children shall include step-children, legally pre-adopted, adopted children, or foster children permanently residing in the participant's household and principally dependent upon the participant for maintenance and support.

If a participant should die, a surviving dependent will have 60 days from the date of the death to elect continuing coverage under the plan. Non-election by the surviving dependent will render him/her ineligible to re-enter the plan at a later date.

How to Enroll

You elect coverage by completing an enrollment form provided by your employer.

You must complete an enrollment form to begin your coverage. You are eligible to enroll only:

- during open enrollment or the initial enrollment period following the date of hire
- due to divorce
- if spouse loses coverage through his/her employer
- due to death of the participant

Check with your employer to find out when your coverage begins.

Changing your Coverage

If you need to add a spouse or child to your coverage, you must complete and return to your district a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, birth or adoption (or beginning of adoption proceedings) or other event making the child eligible for coverage, **if you return to us a completed application and requested documents within 60 days of the wedding, birth or adoption or other event.** If you do not return a completed form and documentation within 60 days, your spouse or child will be added to your coverage as of the next premium due date after we receive the completed form and requested documentation.

When Coverage Ends

Your coverage will end on the earliest of the following:

- The date your eligibility ends, as determined by your employer.
- When you are no longer an eligible employee.
- When you stop making contributions (if applicable).
- When your employer cancels their group coverage.

When you no longer are an active employee, you may continue alternative coverage on an individual basis.

Coverage for all your dependents ends when your coverage ends, or when you stop making contributions, (if applicable), whichever happens first.

Coverage for your dependents ends sooner if one of the following happens:

- The dependent becomes an employee covered under another health-care plan;
- The dependent is no longer an eligible dependent.

Disability

Your employer may continue coverage when you are away from work because of a disability. The limits will be as determined by your employer. If you become Medicare eligible because of a disability, see section on Medicare.

OBRA

Under the Omnibus Budget Reconciliation Act (OBRA), when you and/or your dependent is disabled and entitled to Medicare, the Genesee Area HealthCare Plan remains primary if:

- You are considered actively working;
- Your employer group employs 100 or more employees 50% of the year.

If you are not actively working or your employer employs less than 100, Medicare is your primary payer.

Temporary Layoff or Leave of Absence

Your employer may continue coverage if you are away from work due to a temporary layoff or leave of absence. The limits will be as determined by your employer.

When You Reach Age 65

Medicare

For retired participants age 65 or older or Medicare eligible due to a disability, benefits that would otherwise have been payable under the plan for any charge will be reduced by the amount of any medical benefit that either is payable for the charge under Medicare or would have been payable if the covered participant had enrolled for Medicare Part A and B.

Contact your local Social Security office to enroll in Medicare 2 to 3 months prior to reaching age 65.

Notify your school district once you have your Medicare Card.

If you are actively employed after the age of 65, or a dependent of an active employee, under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), your health insurance provided by Genesee Area Healthcare Plan continues to be your primary insurer.

TEFRA makes the health insurance offered through your employer the primary coverage. If you choose Medicare as your primary coverage, you may not receive supplemental coverage through your employers group plan. You may, however, purchase supplemental coverage on your own.

When You Terminate Employment

If you become self-employed or unemployed, you may continue alternative coverage on an individual basis.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), requires employers with 20 or more employees to offer continuation of group health coverage to "qualified beneficiaries" under the following conditions:

- Termination of employment or reduction in hours causing loss in coverage (18 months);
- Death of the employee (36 months);
- Divorce or legal separation (36 months);
- Dependent children who become ineligible for coverage due to age limitation or marriage (36 months);
- Qualified beneficiaries with a disability.

Your employer will assist you in determining if and when you are eligible and will help arrange for continued coverage.

At the end of this continuation period, a qualified beneficiary may be eligible to continue alternative coverage on an individual basis.

HIPPA

The federal government issued draft regulations April 1, 1997 regarding the Certificate of Group Health Plan coverage required under the 1996 Health Insurance Portability and Accountability Act (HIPPA). The intent of the law was to permit "portability" of insurance by eliminating most waiting periods for pre-existing conditions through crediting prior coverage towards these waiting periods. The prior coverage would be verified when the policy holder loses coverage from an existing policy through issuance of a Certificate of Group Health Plan Coverage (Certificate).

The law requires that written certification of an individual's period of creditable coverage must be provided:

- At the time the individual's coverage under the plan terminates.
- At the time COBRA continuation of coverage ceases.
- On the request of the individual within 24 months after the individual loses coverage under the plan or COBRA whichever is later.

YOUR BENEFITS

Your Preferred Provider Organization (PPO) shares the cost with you for covered services. Here is how shared payments work.

In-Network

When you receive care or treatment from a provider (hospital, doctor or other healthcare provider) whom or which is part of the Preferred Provider Organization Network, covered services are generally covered at 100% or a \$10* charge per visit.

Out-of-Network

A Hospital, Doctor or other health care provider that does not have an agreement with any BlueCross and/or BlueShield Preferred Provider Organization Plan.

*Annual deductible of \$250 per member, \$750 family maximum per calendar year. Plan then pays 80% of covered services until your deductible and copayment total \$2,000 per member, then plan pays 100% of most covered services for the remainder of the year.

What Your Plan Coverage Pays

Your coverage pays 100% less a copayment if required at the time of service for eligible In-Network expenses or 80% for Out-of Network expenses, after deductible.

Precertification - 1-800-363-4658 - Effective July 1, 2001

The Benefit Management Program (BMP) is a mandatory program for subscribers of Genesee Area Healthcare Plan (GAHP). Subscribers of the plan must call BMP anytime their physician or other provider recommends any of the following services:

- Organ Transplant
- Home Care Services
- Rehabilitative Services
- Inpatient Mental Health Care

The call must be made at least 48 hours before the service is delivered whenever possible.

If precertification is not obtained, a \$500 penalty will be applied to the benefit. BMP's hours of operation are 8:30 am to 4:30 PM EST, Monday through Friday at 1-800-363-4658. In order for you to receive full medical plan benefits, it's important that you follow BMP's Care Management Program guidelines.

Following the initial call to the patient service representative, your case is then referred to a BMP care manager, who is a qualified health professional. The BMP care manager will contact your doctor to discuss your treatment plan. Based on the information your doctor provides, the treatment plan will be evaluated for medical appropriateness. Reviews are generally completed within 24 hours, assuming all necessary information is available. Your doctor can call BMP directly which may further facilitate the review process.

Inpatient Hospital Care

When it is medically necessary for you to be hospitalized, you are covered for unlimited days of inpatient care in a hospital. This includes detoxification.

The Plan pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital while you are an inpatient. These benefits include the use of operating, recovery and delivery rooms. A private room is covered if medically necessary, subject to review by us.

Medical Care as an Inpatient

When it is medically necessary for you to be hospitalized, your coverage pays for medical visits by a physician while you are a registered bed patient. Your medical care coverage is for unlimited days, the same as your inpatient hospital benefits. The medical visits are for care of illness or conditions other than those related to surgery or maternity.

*Subject to an inflationary escalator each calendar year based on the consumer price index.

Inpatient Psychiatric and Chemical Dependency - Precertification Required

When it is medically necessary for you to be hospitalized, your coverage provides 30 days of inpatient psychiatric and chemical dependency care, per member, per calendar year. This is a combined benefit for inpatient psychiatric and chemical dependency.

Your coverage pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital/institution while you are an inpatient.

Inpatient Skilled Nursing Facility Care

When it is medically necessary for you to be in a Skilled Nursing Facility (SNF), your coverage provides unlimited inpatient days for SNF care.

Your coverage pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the SNF while you are an inpatient.

Home Care - Precertification Required

When your doctor prescribes care by a home health agency you are covered for home care services. All home health care must be arranged by the home care agency. The plan covers:

- Nursing care;
- Physical therapy and occupational therapy;
- Home maker/visiting health aide--provided only as long as personal care assistance is required. This is not for housekeeping, meal preparation or companion services;
- Social casework--personal/family problems; long-term planning;
- Speech evaluation and therapy;
- Complete laboratory tests;
- Hospital equipment, medical supplies and drugs;
- Inhalation therapy and intravenous therapy;
- Transportation of patients and equipment;
- Ambulance.

Hospice Care

As an alternative to hospital care, a hospice program provides care for the terminally ill on a 24-hour-a-day basis.

Maternity Care-Hospital Billed

Your maternity coverage includes care for a normal pregnancy, complications of a pregnancy, an ectopic pregnancy, caesarean section, or miscarriage and provides for maternity care for dependent children.

Your maternity benefits pay the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital while you are an inpatient. Maternity coverage is provided for 48 hours for normal delivery and 96 hours for a cesarean section. The mother may opt to leave the hospital earlier than the 48 or 96 hours, but can request one covered home care visit. The home care visit must be provided within 24 hours after discharge or at the mother's request, whichever is later.

Maternity Care-Physician Billed

Medical and surgical coverage for maternity care includes care for normal pregnancy, complications of a pregnancy, an ectopic pregnancy, caesarean section, or miscarriage, and provides for maternity care for dependent children. Maternity care includes prenatal and postnatal care, anesthesia.

Coverage For Newborns

Your Plan coverage provides for routine newborn nursery care services and 2 physician visits.

Premature infants and infants with congenital conditions or illness requiring care in excess of routine newborn nursery care are covered from birth.

Routine Adult Physicals

One routine physical and related lab tests per year at \$10 charge per visit In-Network only.

Mammography Screenings

You are covered annually for a mammogram. Covered in full if service rendered by an In-Network provider. Out-of-Network Provider covered at 80%, subject to deductible. We will cover one routine mammogram every calendar year.

Well Child Visits

We will cover well child visits, immunizations, laboratory tests and other services ordered at the time of the visit at 100%, based on the American Academy of Pediatrics standards.

Outpatient Psychiatric Care

Your coverage pays 100% of the charge for the first \$500 then 80% per visit for outpatient psychiatric care when rendered by an in-network provider, up to a maximum 20 visits per member, per calendar year. The 20 visits are a combined annual maximum for in and out-of-network benefits, per calendar year. Out-of-network providers are covered at 50%, subject to the deductible up to the maximum of 20 visits per member per calendar year. The 20 visits are a combined annual maximum for in and out-of-network benefits.

Outpatient Alcohol/Chemical Dependency

Your Plan benefits cover up to 60 visits per member at 100% for an in-network provider and 80% subject to the deductible for an out-of-network provider, per calendar year for outpatient alcohol and chemical dependency care when provided by an approved provider. Additional services beyond 60 visits covered at 80% for in-network providers and 50% for out-of-network providers. The 60 visits is a combined benefit with in and out-of-network benefits. In addition, 20 days are provided for family counseling.

Surgical Care

The Plan pays for surgical procedures and the necessary care by the physician before and after the operation. Surgical care also includes the correction of fractures and dislocations.

Second Surgical Opinion

Your Plan coverage pays for a second opinion for proposed non-emergency surgery. The second opinion must be given by a surgeon certified by the appropriate state agencies.

Anesthesia

Your coverage pays for the administration of anesthesia in connection with surgery, maternity care and other covered services.

Emergency Services

Life threatening and urgent medical emergencies covered in-network with a \$50 copayment per visit unless admitted as an inpatient to the hospital. Emergency room for out-of network providers is covered at 80% of allowed charges, subject to the deductible.

Ambulance Service

The first \$250 paid at 100%, the balance covered at 80%.

Emergency transportation services by a professional ambulance to or from the hospital or by a regularly scheduled airline, railroad, or air ambulance to the nearest hospital qualified to provide necessary treatment, and other medically necessary ambulance transportation to and from a medical facility.

Supplemental Accident

If a covered participant suffers an accidental bodily injury while covered, and there are charges that are not payable under other provisions of this plan, then such excess expenses shall be paid under this benefit.

The expenses must be incurred within 90 days of the accident and will be reimbursed under the provision to a maximum of \$300 per accident.

PROVIDER REIMBURSEMENT

Care By In-Network Provider

According to contractual agreement with participating providers.

Care By Out-of-Network Provider

According to usual and customary charge. The usual and customary charge is a fee or charge by most providers with similar training and experience for a particular service, procedure, or health care item in the geographic area where the service is rendered. Any additional amount billed by the physician is your responsibility.

EXPERIMENTAL AND/OR INVESTIGATIONAL - means any medical treatment, procedure, drug, substance or device

- that is the subject of ongoing Phase I,II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
or
- for which a written protocol or protocols or written informed consent, used by the treating facility or provider, (or the protocol(s) or written informed consent of another facility or provider studying substantially the same medical treatment, procedure, drug, substance, or device), identify the medical treatment, procedure, drug, substance or device as a research or investigational or experimental study or a clinical trial; or
- that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("USFDA") and approval for marketing has not been given at the time the drug or substance or device is furnished; or
- that is a drug or substance or device which is not, at the time it is furnished, approved by the the USFDA for the specific diagnosis for which the patient is being treated; or
- that is a drug or substance or device which is labeled: "Caution-limited by federal law to investigational use" or a substantially similar label or warning.

BLUECARD PROGRAM

Blue Cross and Blue Shield participating provider networks throughout the United States are available to you through the BlueCard Program. So no matter where you live, work, or travel, you can take advantage of the national Blue network.

GAHP has contracted with Excellus BlueCross BlueShield, Rochester Region to administer your medical care benefits plan. Excellus BlueCross BlueShield, Rochester Region has partnerships with other Blue Cross Blue Shield Plans around the country to see that employees and their families, living outside the Rochester region, are also covered through your employer's plan with Excellus BlueCross BlueShield, Rochester Region.

The Excellus BlueCross BlueShield, Rochester Region partnership with the national Blue Cross and Blue Shield Association, enables you to take advantage of the largest network of participating providers in the country. *This unique national partnership is called the BlueCard Program.*

When you use participating providers, you save, because fees for participating providers are paid as In-Network benefits.

Access to Physician and Hospital Networks

Whether you live in Washington D.C. or Phoenix, Arizona; or your son or daughter is heading to college in Buffalo; or you're planing a vacation in Miami, you can take advantage of the BlueCard Program.

Coast-to-Coast Network

More than 80% of all hospitals and physicians throughout the United States contract with independent Blue Cross and Blue Shield Plans. This is now **your** network through the BlueCard Program. Only BlueCard members have access to this vast provider network of traditional participating providers!

Your BlueCard ID card, which is recognized by Blue Cross and Blue Shield providers anywhere in the U.S., links you to this vast provider network.

The small "suitcase" on your ID card with "PPO" inside, alerts providers of your membership in the nationwide BlueCard Program.

You have the option of using any provider, regardless of whether they are part of the Blue Cross and Blue Shield participating network, but remember, when using providers outside the network, your share of the cost will likely be higher.

How to Find a Participating Provider

If you are out of town and get sick, or if you or a family member live outside the Excellus BlueCross BlueShield, Rochester Region service region and need to find information about a Blue Cross and Blue Shield Plan PPO physician or hospital, just call the local BlueCard PPO Network Doctor and Hospital Information Line at 1-800-BLUE (2583). You will receive assistance in locating the nearest PPO network doctor or hospital.

You may also reference the Website at WWW.BCBS.COM

In addition, you may always call your Excellus BlueCross BlueShield, Rochester Region customer service department at the 800 number on your ID card for help.

It's Simple to Use the Network!

- Visit a Blue Cross and Blue Shield Plan Physician and show your ID card with the "suitcase" and PPO at the top.
- The provider quickly verifies your membership and coverage.
- **In most cases, you are responsible to pay the applicable copayment**
- Providers submit all charges to the local BlueCross BlueShield Plan.

Important:

Many geographic areas have established specialty networks, such as clinical labs, physical therapists, infusion therapy networks and ambulatory surgical centers. If you are referred to specialty providers, ask ahead if they participate with the Preferred Provider Organization Network. The savings you can realize will make it worth your while.

Emergency Care

In an emergency situation, seek medical treatment immediately. Do not be concerned about whether the nearest emergency room is part of the BlueCard participating network.

An emergency is a sudden, serious acute illness, injury or condition, including sudden and severe pain, which could endanger your health if not medically treated immediately.

Hospital Care

When a hospital admission is necessary, you and your doctor most likely will plan in advance where you will go, what needs to be done and how long you will be in the hospital. Remember, in order to obtain maximum benefits, please verify whether you are using network or non-network providers.

No Claim Forms

There are virtually no claim forms for you to fill out or submit when you receive care from a Blue Cross and or Blue Shield PPO network provider.

However, if you use a non-network provider, you may have to pay the bill at the time of service and then file a claim for your reimbursement.

Remember to Always Carry Your ID Card

Providers will need to see your ID card to verify your membership in the BlueCard Program, so it's a good idea to keep it with you at all times. Remember, the card is your link to health care networks-special rates-no hassle.

If you have questions or need information about the BlueCard Program, call Excellus BlueCross BlueShield, Rochester Region Customer Service using the 800 number listed on your BlueCard ID card.

OTHER COVERED SERVICES

- Outpatient surgery, including associated laboratory tests and X-ray services;
- Ambulatory surgery facilities, and services in hospital clinics and one-day surgery centers;
- Medical emergencies and accidental injuries;
- After Hour/Urgent Care Facilities;
- Radiation therapy and Chemotherapy;
- Inhalation therapy, occupational therapy and physical therapy;
- Speech therapy;
- Pre-admission testing within seven days of a hospital admission;
- Laboratory, pathology and X-ray services;
- Home and office care;
- Annual routine GYN exams and Pap smears;
- Physician services in the emergency room;
- Ambulance services to the nearest hospital and between hospitals when medically necessary;
- Durable medical equipment, appliances, dressing and medical supplies which are accompanied by a physician's prescription or statement of medical necessity;
- Eyeglass lenses or contact lenses required after cataract surgery;
- Chiropractic services;
- Internal prosthetic devices;
- External prosthetic, custom-made supports and orthopedic braces;
- Dental care as a result of accidental injury to sound and natural teeth occurring after the effective date of your contract. The services must be rendered within 365 days of injury;
- Acupuncture services and related therapeutic treatment rendered by a state licensed acupuncturist.

GENERAL EXCLUSIONS

You are not covered for services and supplies that:

- Are not prescribed by a physician or other approved provider;
- Are not considered medically necessary for your diagnosis or treatment;
- Are given by other than hospitals, physicians and other approved providers;
- Are experimental or of a research nature (see explanation);
- Are already covered by another insurance contract;
- Are payments for any illness or injury that happened because of your employment if worker's compensation benefits are available - whether or not you claim those benefits;
- Are payments for any illness or injury that are covered under the mandatory no fault insurances.

You are not covered for an illness or injury that:

- Is the result of any act of war;
- You would not have a legal obligation to pay.

You are not covered for:

- Inpatient bed rest charges, for telephone consultations, missed appointments or fees sometimes added for filling out a claim form;
- Personal comfort items;
- Radio/television rentals;
- Personal convenience items such as air conditioners, humidifiers, physical fitness equipment and other such devices;
- Custodial care such as sitters, homemaker's services or care in a place that serves you primarily as a residence when you do not require skilled nursing care;
- Surgery to improve appearance, except when it is needed to correct certain birth defects or to correct conditions which result from accidental injury or disease;
- Foot care, except some joint, ligament and bone surgery;
- Refractions and eye examinations, unless required after cataract surgery;
- Eyeglass or contact lenses, unless required after Cataract surgery;
- Transsexual surgery, sex reassignment;
- Blood plasma or derivative, except blood for hemophiliac patients;
- Services normally covered by Medicare (if Medicare eligible);
- Marriage counseling and all services rendered by a marriage counselor;
- Obsolete procedures;
- Diets and food supplements;
- Care and treatment of the teeth and gums except as previously stated;
- Counseling services and mental health therapy provided by other than a licensed psychiatrist, or a licensed psychologist, or a certified social worker;
- Hearing Aids;
- Charges for assisted reproductive technologies including but not limited to in-vitro fertilization; artificial insemination; GIFT,ZIFT;
- Routine service other than those listed.

COORDINATION OF BENEFITS

Most group health care programs, including the Genesee Area Healthcare Plan, contain a coordination of benefits provision. This provision is used when you, or your spouse or your covered dependents are eligible for payment under more than one group health program. The objective of coordination of benefits is to assure you that your covered expenses will be paid, but that the combined payments of all the programs do not amount to more than the actual cost of your care.

Here is how the coordination of benefits provision in your Genesee Area Healthcare Plan coverage works:

When your other group coverage does not mention coordination of benefits, then that coverage pays first. Your Genesee Area Healthcare Plan coverage pays the balance owed for your covered services in accordance with policy provisions.

When the person who receives care is covered as an employee under one group contract, and as a dependent under another and both contracts contain a coordination of benefits provision, then the employee coverage pays first.

When a dependent child is covered under both its parents' group contract, the contract of the parent whose birthday falls earlier in the year is primary and will pay its benefits first. The year of birth is not used in this rule. If both parents have the same birthday, the policy that has been in effect the longest will pay its benefits first. This does not apply to children of separated or divorced parents. The policy of the parent who is legally responsible for providing health coverage for the child will pay its benefits first. If there is no court decree for health care coverage, then the policy of the parent who has custody of the child will pay its benefits first.

If your benefits are coordinated, and you receive more than you should have for the service or care provided, you will be expected to repay any overpayment.

Subrogation

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident and we pay benefits as a result of that injury or illness, we will subrogate and succeed to your right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid. This means that we have the right independently of you to proceed against the party responsible for your injury or illness to recover the benefits we have paid.

CLAIMS

How to File A Claim

Participating hospitals and skilled nursing facilities and physicians will submit the claim directly to the local Blue Cross and Blue Shield Plan when you show them your identification card. Your Blue Cross and Blue Shield identification card provides claims filing instructions for providers of care.

Claims not filed by the provider, such as durable medical equipment should be sent directly to Excellus BlueCross BlueShield by you.

Claim filing limit is 18 months from date of service.

Where to file a Claim

Submit the completed claim form and itemized bills to:

Excellus BlueCross BlueShield, Rochester Region
165 Court Street
Rochester, New York 14647

Explanation of Benefits

After your claim is processed, you will receive an Explanation of Benefits (EOB) statement from us. The EOB indicates what action was taken on your claim — specifically, which services were covered and which, if any, were not.

How to Read an Explanation of Benefits Statement

You will receive an EOB whenever a claim has been processed, whether or not payment has been made. Here is what you will find on your EOB:

- Your name and address;
- Your identification number and the name of the patient;
- The date the service was provided;
- The type of service that was rendered;
- The total amount charged for that service;
- Any amount of the total charge that was not a covered expense;
- The total covered expenses;
- The amount of the covered expense applied to your deductible, if applicable;
- The copayment;
- Our total payment;
- Payment summary.

In addition to receiving the EOB when you file a claim, you will also receive an EOB when a provider files a claim.

Both these EOBs list a claim number or a transaction number. Please have this number and the EOB statement available when you call with a question.

Claim Appeal Procedure

If a claim for benefits is denied either in whole or part by us, you will receive an Explanation of Benefits statement explaining the reason for the decision.

You may request further explanation of this decision by calling or writing our Customer Service Department.

If you are not satisfied with the explanation given you by our Customer Service Department, you may appeal a denial of benefits for any claim or portion of a claim by sending a written appeal along with any additional information to:

**Vice President of Claims
Excellus BlueCross BlueShield, Rochester Region
165 Court Street
Rochester, New York 14647-0786**

This written appeal must be made within 60 days after you have been notified of the denial of benefits.

A further review will be made of all the facts on which the original decision was based and also any additional information you have provided.

You will be informed of the decision within 60 days, unless additional materials are requested in a timely fashion by us.

In the event that an enrolled participant desires an appeal of Excellus BlueCross BlueShield, Rochester Region's determination of a claim, the participant may appeal to the Genesee Area Healthcare Plan Board of Directors at: Executive Director, Genesee Area Healthcare Plan, Genesee Valley BOCES, 80 Munson Street, LeRoy, NY 14482.

EXTERNAL APPEAL

You may file an application for an external appeal by a state approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a notice of final adverse determination as a result of the BlueCross BlueShield internal appeal process (first level of the plan's internal appeal process) OR they must have jointly agreed to waive the internal utilization review appeal process.

You may obtain an external appeal application:

- from the New York State Insurance Department at 1-800-400-8882, or its website (www.ins.state.ny.us);
- from the New York State Department of Health at (518) 486-6074, or its website (www.health.state.ny.us);
or
- by contacting Excellus BlueCross BlueShield.

The application will provide clear instructions for completion. A fee of \$50.00 may be required to request an external appeal. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet the Excellus BlueCross BlueShield criteria for a hardship exemption.

The application for external appeal must be made within 45 days of your receipt of the notice of final adverse determination as a result of the Excellus BlueCross BlueShield appeal process or within 45 days of when they jointly agree to waive the internal appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the internal appeal. A final adverse determination is the determination of the healthcare plan's first level of internal appeal. You cannot be required to seek a second level of internal appeal with your health plan in order to request an external appeal.

The application will instruct you to send it to the New York State Department of Insurance. You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the state will review your request to determine if the denied service is medically necessary and should be covered by us. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both you and Excellus BlueCross BlueShield.

An external appeal agent must decide a standard appeal within 30 days of receiving your application for external appeal from the state. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different that considered by Excellus BlueCross BlueShield, they will have three (3) additional business days to reconsider or affirm their decision. You will be notified within 2 business days of the agent's decision.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three (3) days for expedited appeals. Every reasonable effort will be made to notify you and Excellus BlueCross BlueShield of the decision by phone or fax immediately. This will be followed immediately by a written notice.

GLOSSARY

Ambulatory surgery facility:

A facility with an organized staff of physicians that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- Provides nursing services and other treatments by or under the supervision of physicians whenever the patient is in the facility;
- Does not provide inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a physician or other professional.

Contract holder:

An eligible person who has enrolled for coverage.

Claim form:

A form you must file to receive benefit payments that are due you. Claim forms are designed to provide all the information necessary for the prompt, efficient processing of your claim.

Contract maximum:

The total amount of benefit payments, according to your contract. Maximums are sometimes set for certain benefits, for the benefit years, or for the life of your contract.

Coordination of Benefits:

A cost-sharing mechanism through which benefits covered by more than one carrier are coordinated to allow maximum cost effectiveness and minimize multiple payments for a single service.

Copayment:

A percentage of the provider's charge for which you are responsible after you meet your deductible. For many services included in your coverage, your copayment is \$10 for In-Network benefits.

Covered family members:

You, your spouse and dependent children covered under the Plan.

Covered service:

A service or supply, shown in the contract and rendered by the provider, for which benefits are provided.

Deductible:

A cost-sharing mechanism that requires you to pay a calendar plan year amount before your coverage provides payment. (Out-of-network only.)

Dependent:

A covered person other than the contract holder.

Diagnostic service:

A test or procedure performed when you have specific symptoms to detect or monitor your disease, illness, or injury. It must be ordered by a physician or other professional provider. Diagnostic services include, but are not limited to:

- X-ray and other radiology services needed for diagnosis of disease or injury;
- Laboratory and pathology services;
- EKGs and EEGs.

Explanation of Benefits (EOB)

The statement mailed to you after your claim has been processed. It describes the services billed to us and the amount of payment made.

Home health care agency: Precertification Required

An organization that:

- Provides skilled nursing care and other services on a visiting basis in the covered person's home;
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending physician.

Hospital

A licensed institution primarily engaged in providing:

- Inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis;
- Treatment and care of injured and sick persons by or under the supervision of physicians;
- 24-hour nursing services by or under the supervision of registered nurses.

Identification card:

A card with information necessary for claims processing. Your subscriber identification number is listed on your card. The card is used to identify you and your dependents who are enrolled in the benefits program. Carry the card with you at all times.

Medically necessary:

Services or supplies that are required to identify or treat an illness or injury and are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition;
- Appropriate with regard to standards of good medicine;
- Not solely for the convenience of the patient, the provider or the hospital;
- The most appropriate supply or level to safely treat the patient. When treating an inpatient, medically necessary also means that the patient's condition requires that the services cannot be provided on an outpatient basis.

Non-covered:

A service not covered by your plan;

Non-member hospital:

Any hospital with which no agreement has been made with Blue Cross for rendering hospital services.

Out-of-pocket limit:

A specified dollar amount of copayment expenses incurred by a covered person for covered services in a benefit period. Such expense does not include charges in excess of the provider's reasonable charge or any copayments for benefits covered at 50 percent. When the out-of-pocket limit is reached, the level of benefits is increased.

Outpatient:

A covered person who receives services or supplies while not an inpatient.

Outpatient psychiatric facility:

A facility that mainly provides diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Precertification:

Review and certification of certain medical services to ensure medical appropriateness.

Prescription drug:

Any medicinal substance, the label of which, under the Federal Food, Drug & Cosmetic Act, must bear the legend: *Caution: Federal Law prohibits dispensing without a prescription.*

Provider

A hospital, physician, health professional or other facility, licensed under applicable state laws to include the following:

Facilities-

- Hospital;
- Ambulatory surgery facility;

-
- Dialysis facility;
 - Home health care agency;
 - Outpatient psychiatric facility;
 - Pharmacy or laboratory;
 - Skilled nursing facility;
 - Chemical dependency treatment facility;

Professionals

- Doctor of Medicine (M.D.);
- Doctor of Osteopathy (D.O.);
- Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C);
- Doctor of Dental Surgery (D.D.S.);
- Chiropractor (D.C.);
- Nurse Practitioner;
- Physical Therapist;
- Clinical Psychologist;
- Registered Nurse (R.N.);
- Licensed Practical Nurse (L.P.N.);
- Licensed Speech Therapist (S.P.);
- Licensed Occupational Therapist (O.T.);
- Certified Social Worker.

Allowed charges;

The charge that the plan determines is reasonable for covered services provided to you. The reasonable charge for a contracting provider is established by the agreement between the provider and us.

Psychiatric hospital: Admissions require Precertification

A facility that mainly provides diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist:

A licensed clinical psychologist. In states where there is not a license law, the psychologist must be certified by the appropriate professional organization.

Skilled nursing facility:

A facility that mainly provides inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of an organized staff of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

- Minimal custodial, ambulatory, or part-time care;
- Treatment for mental illness, alcoholism, chemical dependency or pulmonary tuberculosis.

Substance abuse treatment facility:

A facility providing detoxification and/or rehabilitation treatment for alcoholism or chemical dependency .

Surgery:

- The performance of generally accepted operative and other invasive procedures;
- Usual and related pre-operative and post-operative care;
- The correction of fractures and dislocations;
- Other procedures as approved by the Plan.

Usual, Customary and Reasonable Amount:

The amount the Plan determines is reasonable for covered services provided to you. The reasonable amount for a contracting provider is established by the agreement between us and the provider. In the case of physician or other professional provider, the provider's reasonable amount is the usual, customary and reasonable amount.

OPTIONAL RIDERS

Participants are required to remain in a rider for a minimum of two years.

DENTAL PLAN I BENEFITS

Dental Plan I is designed to provide basic dental coverage for the most commonly performed procedures.

Preventive and Restorative Services

Initial Examination	\$6
Full-Mouth X-rays	\$20
Biopsy (hard/soft)	\$24/\$20
Prophylaxis (cleaning)	\$12
Fluoride Treatment (to age 19)	\$6
Restorations	
Amalgam(adult) 1/2/3 surfaces	\$10/\$14/\$17
Resin 1/2/3 surfaces	\$8/\$10/\$13
Root Canal (Endodontia) 1/2/3 canals	\$50/\$80/\$100
Emergency Treatment (sedative filling, recement cr., etc.)	\$10
Repairs to Dentures	\$13
Adding One Tooth	\$17
Each Additional Tooth	\$6
Simple Extractions (initial)	\$10
Subsequent	\$10

Orthodontia Services

Initial Exam (including cephalometric study, treatment plan and study models)	\$40
Placing of Appliances	\$100
Monthly Payments	\$20
Maximum Dollar Amount (per individual)	\$600
Maximum of 2 years of active treatment	

Exclusion

Procedures not listed above are not covered under Dental Plan I

DENTAL PLAN II BENEFITS

Dental Plan II represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of reasonable charges. The following are covered under this category:

1. Oral Examinations (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays
 - a. Full-Mouth Series (once every 3 years)
 - b. Bitewings (once per year)
4. Topical fluoride application through age 19.
5. Emergency treatment.
6. Sealants through age 16.

Restorative Services

After satisfaction of the \$25 annual individual deductible, or the \$50 family deductible, restorative services are paid at 100% of the reasonable charges.

Basic restorative services, which require no pre-determination of benefits, including the following:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam, plastic, silicate and composite restorations)
4. Oral surgery - including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan
5. Periodontics - including gingival curettage, gingivectomy and gingivoplasty
6. Osseous surgery (bone surgery)
7. Repair of dentures.

Major restorative services, for which pre-determination estimates **are required**, including the following:

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays).
2. Inlays, crowns, (not part of a bridge) and space maintainers.
3. Orthodontics.

Dental Plan II Maximums

For orthodontia services, no more than \$1,500 in the individual's lifetime will be covered. For all other covered services, the maximum payable in a calendar year shall be \$1,500 per individual and \$3,000 per family.

DENTAL BENEFITS EXCLUSIONS

Coverage under Dental Plan I or Dental Plan II will not apply to:

1. Charges for dentures or bridgework (including crowns and inlays forming the abutments) when such charges are incurred for replacement teeth, all of which were extracted prior to the date the individual became a covered employee;
2. Charges for services not considered necessary and appropriate;
3. Charges for replacement of a lost or stolen prosthetic device;
4. Charges for dentistry for cosmetic purpose, including the alteration or extraction and replacement of sound teeth to change appearance;
5. Charges for the replacement of dentures less than 5 years after a preceding placement, except a replacement made necessary by the initial placement of an opposing full denture which necessitates the replacement of an existing denture.
6. Charges incurred for myofunctional therapy, oral hygiene, dietary or plaque control programs or other educational programs.
7. Charges in connection with an injury or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.

VISION BENEFITS

Examination

The Plan will pay for the reasonable charge for a vision exam, including glaucoma testing, once every two calendar years.

Lenses

The Plan will pay for prescription eyewear every two calendar years up to a maximum benefit of \$100.

You may see a vision provider of your choice. Please fill out a Genesee Area Healthcare Plan medical claim form and send it to:

Excelsus BlueCross BlueShield, Rochester Region
165 Court Street
Rochester, New York 14647

Medical claim forms are available through your employer or by calling (585) 325-3630 or toll-free (800) 847-1200, or on-line at www.excellusbcbs.com.

Your Routine Vision Plan excludes services related to cataract surgery. These services are covered under your medical benefit plan.

PRESCRIPTION DRUG BENEFIT

The prescription Drug Plan is managed by AdvancePCS Systems.

Benefits are provided under the Prescription Drug Program for the following drugs:

1. Legend Drugs: A "Legend Drug" is a drug or compound which requires a Prescription Order and which is required by law to bear the legend "Caution-Federal Law prohibits dispensing without prescription."
2. Drugs which are not Legend Drugs but which require Prescription Orders under New York State Law.
3. Prescriptions which consist of two or more ingredients, one of which is a drug defined in 1 or 2 above
4. Insulin and syringes.

Benefits are provided for the above described drugs only when a written Prescription Order is presented to the pharmacist for the drug, except that a Prescription Order is not required for insulin.

A "Prescription Order" is a written request for drugs signed by a doctor in the course of his or her profession. A "doctor" means only a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), or a Podiatrist.

Remember to show your Prescription Drug Identification Card at the time of the purchase.

Prescription Drugs Obtained at a Participating Pharmacy

If your prescription order for drugs covered under this program is filled, or if insulin is obtained, at a participating pharmacy, effective July 1, 2003, you or your dependents will pay the following co-payments:

Retail (at the pharmacy) <i>Co-payment applies for each 34-day prescription</i>	Mail Order <i>Co-payment applies for each 105-day prescription</i>
\$5 Generic	\$10 Generic
\$10 Preferred Drug* (Tier 2)	\$20 Preferred Drug*
\$25 Non-preferred Drug* (Tier 3)	\$50 Non-preferred Drug*

***Preferred vs. Non Preferred Drugs:** The determination is made by AdvancePCS. They strive to identify the most cost-effective drugs for each medical condition, and these drugs are identified as preferred. A preferred option exists for almost all drug categories. When visiting your doctor, bring the preferred drug list with you. (If you need a booklet, contact your Business Office or the GAHP Office or visit www.druglist.com.)

The co-payment will be subject to an inflationary escalator each calendar year based on the Consumer Price Index.

DRUG LIMITATIONS

Some drugs are limited to a specified amount per prescription. Others must go through a prior authorization process with AdvancePCS or Genesee Area Healthcare Plan. The following is a list of drugs presently in one of the categories as of July 1, 2001. As new drugs enter the market place, changes may be made to the list of drugs requiring prior authorization.

- **Prescription is limited to a specified amount:**

DRUG	INDICATIONS	LIMITATIONS
Relenza, Tamiflu	Anti-flu drugs	2 courses/year
Imitrex Tablets	Migraine	18 pills/25 days 25mg or 50mg
Zomig	Migraine	12 2.5mg pills/25 days 6 5mg pills/25 days
Viagra	Erectile Dysfunction	6 pills/25 days
Maxalt	Migraine	12 pills/25 days

• **Prior Authorization (Doctor sends a letter of necessity to GAHP)**

DRUG	INDICATIONS
Retin A*, Avita, Renova	Adult Acne (age 26 and older)
Ritalin	ADD (age 20 and older)

*A 100% co-pay Tier 4 option is available if you are using Retin A for a cosmetic purpose. Ask your pharmacist to put the prescription through at 100% co-pay.

• **Prior Authorization (Doctor communicates with AdvancePCS)**

DRUG	INDICATIONS
Accutane	Severe Acne
Enebrel, Arava	Anti-inflammatory, anti-arthritis
Androgel	Testosterone Replacement
Botox	Medical necessity only - not for cosmetic purpose

A "Participating Pharmacy" is a pharmacy which is licensed as a pharmacy with the appropriate State licensing agency and which has an agreement with AdvancePCS to dispense drugs and insulin under the Prescription Drug Program.

Prescription Drugs Obtained at a Non-Participating Pharmacy

If your Prescription Order for drugs covered under this Program is filled, or if insulin is obtained at a non-participating pharmacy, you or your dependents must pay the non-participating pharmacy's charge for the drug or insulin.

You must obtain a receipt for your purchase and fill out a claim form. A "non-participating pharmacy" is a pharmacy which is registered as a pharmacy with the appropriate State Licensing Agency but which does not have an agreement with AdvancePCS concerning dispensing drugs or insulin under this Program.

Tier 4

This benefit enables participants to purchase, at the GAHP discounted rate, the following categories of non-covered prescription drugs.

- Weight loss (ex. Meridia, Xenecal)
- Hair growth stimulants (ex. Propecia)
- Infertility medications
- Pigmenting/depigmenting agents
- Smoking cessation (ex. Zyban)
- Cosmetic (Retin A, Renova, Avita)
- Ask your pharmacist to process your prescription through AdvancePCS. It will come up as 100% copayment at the plan's discounted price.
- The amount of savings may vary depending upon the pharmacy's original cost.
- Tier 4 drugs may only be obtained at a pharmacy, not through mail order.

PRESCRIPTION DRUG EXCLUSION

No payment will be made under the Prescription Drug Program for the following items, even if these items are prescribed by a doctor:

1. Drugs which do not require a written order under the Federal or New York State law, except insulin.
2. Mechanical devices such as artificial appliances and therapeutic devices
3. Administration or injection of any drug.
4. Vitamins, diet supplement and similar items which can be purchased without a prescription.
5. Drugs which are designated by Federal or New York State law as experimental or investigational.
6. Blood or blood plasma.
7. Drugs dispensed to a covered individual while a patient in a hospital.
8. Drugs dispensed to a covered individual while a patient in a nursing home or other institution, if the cost of the drug is billed by the nursing home or institution.
9. Drugs available under any Federal or State law, including Workers' Compensation Act or similar law, whether or not you or your dependents make any recovery against a third party for damages. Benefits will, however, be provided to you or your dependents if eligible for Medicaid.
10. All drugs prescribed as preventive in nature.
11. Anabolic steroids.
12. Anti-wrinkle agents.
13. Anorectics (drugs used for the purpose of weight loss, e.g. Redux, Fastin). Exceptions: Adderall is covered for individuals through age 19. Dexidrine is covered regardless of age.
14. Topical fluoride substances (oral tablets and oral liquid forms are covered).
15. Infertility medications.
16. Methylphenidate (e.g. Ritalin) for individuals age 20 or older (except for medical necessity).
17. Hair growth enhancement products.
18. Pigmenting/depigmenting products.
19. Retin A for individuals 26 or older (except for medical necessity)
20. Smoking deterrent medications or smoking cessation aids.
21. Immunizations.
22. All prescriptions which are not deemed medically necessary.

AdvancePCS
9501 E. Shea Boulevard
Scottsdale, Arizona 85260
Toll-free #1-800-966-5772

GAHP

How to Contact Us

***Excellus BlueCross BlueShield, Rochester Region
165 Court Street, Rochester, NY 14647***

Benefit and Claims: Customer Service

**585-325-3630 or 1-800-847-1200
Friday 9:00 a.m. - 7:00 p.m.**

Express Line Service

***(Use this number to order ID cards and claim forms)*
1-800-548-6428
24 hours a day / 7 days a week**

E-Mail

Customerservice@excellus.com

E-mail our Customer Service Department with any inquiries

How to Find a PPO Provider

**www.bcbs.com
or call
1-800-810-BLUE (2583)**

