NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

May 22, 2013
Refer to: Kimberly B. Luke, Esq.
File No. 2012120136

Mr. Stephen Locey
Locey & Cahill, LLC
120 Walton Street, Suite 500
Syracuse, NY 13202
Sent Via U.S. Mail

Re: Greater Tompkins County Municipal Health Insurance Plan
Forms: Form #: GTC13-001
Form #: GTC13-002
Form #: GTC13-003

Dear Mr. Locey:

Please be advised that the above-captioned forms have been approved, as of today's date, subject to all explanations and written assurances provided by the company to this Department with respect to this submission. Duplicate copies bearing our Department's stamp of approval are enclosed.

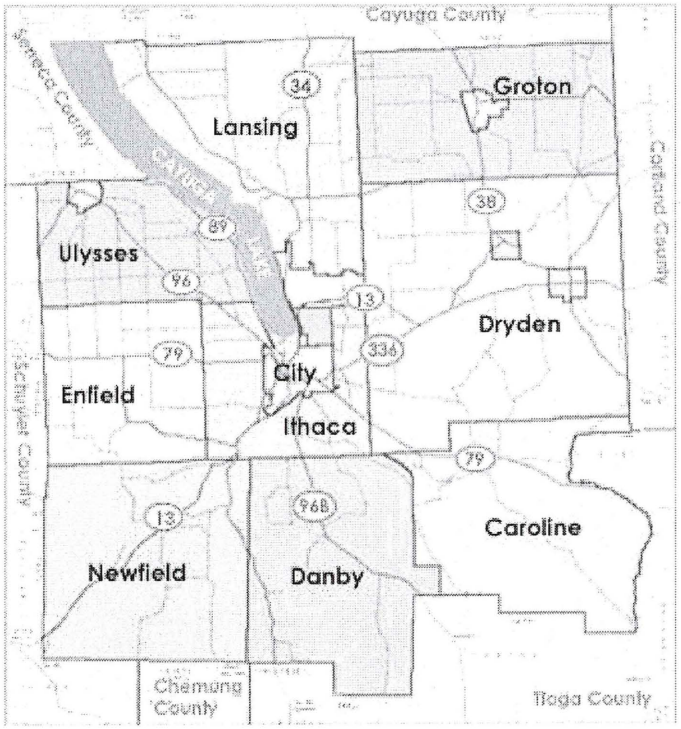
However, please be advised that plans that are issued or renewed after January 1, 2014, will be subject to new requirements under the Affordable Care Act (ACA). As such, new language will need to be submitted by the Plan at that time in order to comply with the requirements of the ACA.

Very truly yours,

Lisette Johnson
Chief, Health Bureau

By: Kimberly B. Luke
Senior Insurance Attorney

Greater Tompkins County Municipal Health Insurance Consortium



APPROVED
STATE OF NEW YORK
MAY 22 2013
SUPERINTENDENT
BENJAMIN M. LAWSKY

Indemnity Plan $50/$150
Rx $1-$1-$1 MO $0-$0-$0
OOP-$400

Greater Tompkins County Municipal Health Insurance Consortium Participants:

County of Tompkins

City of Ithaca	Town of Ithaca
Town of Caroline	Town of Ulysses
Town of Danby	Village of Cayuga Heights
Town of Dryden	Village of Dryden
Town of Enfield	Village of Groton
Town of Groton	Village of Trumansburg

Effective Date: TBD

Form #: GTC13-003

PLAN DOCUMENT

The Greater Tompkins County Municipal Health Insurance Consortium hereby establishes their Health Benefits Plan, (the "Plan"), on the terms and conditions set forth in this Plan Document.

EFFECTIVE DATE

The effective date of this Plan is January 1, 2010, as of 12:01 A.M. Eastern Standard Time at Ithaca, NY. Benefits payable by the Plan to eligible employees, eligible retirees, their eligible spouses or their eligible dependents on account of expenses incurred on or after the effective date shall be determined pursuant to the terms and conditions of this Plan. Benefits payable by the employer to employees or their dependents on account of expenses incurred before the effective date shall be determined in accordance with any applicable employee benefit plan maintained by the employer at the time the expenses were incurred.

FUNDING

Benefits under this Plan, and the administrative costs of this Plan, shall be paid from the general assets of the Greater Tompkins County Municipal Health Insurance Consortium and other participating municipalities and/or by contributions paid by employees and retirees in the amounts, if any, as indicated by the employer and/or except to the extent that the Greater Tompkins County Municipal Health Insurance Consortium may contract with one or more insurance carriers to reimburse or reinsure all, or part of, the benefits provided under this Plan. The premiums required by such insurance contracts shall be paid from the general assets of the Greater Tompkins County Municipal Health Insurance Consortium and other participating municipalities, if any, and/or by contributions paid by employees and retirees in the amounts, if any, as indicated by the employer.

RIGHTS OF EMPLOYEES

This Plan does not provide any benefit not specifically described herein. This Plan does not constitute a contract of employment and does not affect the right of the employer to discharge any employee.

CLAIMS ADMINISTRATOR

The Plan has engaged the services of ***Excellus BlueCross BlueShield of the Central New York Region*** to adjudicate claims and administer benefits according to the provisions of this Plan. In addition, the Plan may engage the services of outside contractors (i.e. Managed Care Consultant, Health Insurance Consultant, Medical Director) to assist in the administration of the Plan.

MISSTATEMENT OF AGE

If the age of the covered person has been misstated on an enrollment form, and age is a factor in determining contribution amount, eligibility, and/or benefits, then eligibility and/or benefits will be adjusted in accordance with the true age of the individual, and contributions so affected will be adjusted on the next contribution date following the discovery of such misstatement of age. Also, any such misstatement of age shall neither continue coverage which has been otherwise validly terminated, nor terminate coverage which is validly in force.

LEGAL ACTIONS

Legal action may not be taken to receive benefits until 60 days after the date of proof of loss is submitted according to the requirements of this Plan. Legal action must be taken within three (3) years after the date, and proof of loss must be submitted.

PAYMENTS UNDER THE PLAN

Payments under the Plan for services provided by an in-network provider will be made directly by the Plan to the in-network provider. If services are received from an out-of-network provider, the Plan reserves the right to pay either the covered person or the out-of-network provider.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of the terms of this Plan and their implementation, the Plan or the Plan Administrator may release to, or obtain from, any other plan administrator, insurance company, other organization, or individual any information needed regarding a covered person which is deemed necessary. Any individual claiming benefits under this plan will need to furnish the information deemed necessary for the determination and implementation of benefits.

DATE EXPENSES ARE INCURRED

Expenses will be considered to be incurred on the latest of the following dates:

1.) the date a medical service or treatment is rendered;
2.) the date a purchase is contracted; or
3.) the date delivery of a purchase is made.

However, should a covered person be facility confined on the termination date of this Plan, the latest date that expenses will be deemed incurred is the date the Plan ceases its operations.

DEDUCTIBLE AMOUNTS

For those expenses not covered at 100%, the individual deductible amount stated in the Benefit Summary Section of this Plan Document must be incurred with respect to a covered person before benefits become payable. If, during a plan year, such deductibles are equal to the family deductible shown in the Benefit Summary Section of this Plan Document, no further deductible amount shall apply with respect to any remaining expenses incurred by members of that family during the remainder of that calendar year. *For the purposes of this provision, a "family" means a covered employee and his or her covered dependents.*

COVERED MEDICAL EXPENSES - Medical Case Management

Certain medical conditions for which a claim is made under the Plan may be referred to Medical Case Management (MCM). MCM is a program which provides a case-by-case analysis and medical treatment plan suggestions that address the needs of covered persons. MCM concentrates on injuries and illnesses when early intervention and individual case management will prove effective to a patient's recovery.

Only those conditions for which there is a potential lower cost treatment alternative, will be recognized for MCM. The decision to implement MCM will remain with the plan administrator who will rely on the criteria established by the case management service provider to determine which claims are recommended for case management.

In certain instances a recommendation to use alternative treatment, non-covered services, or a non-participating facility (excludes services or supplies of an educational, experimental or investigatory nature) may be made when such treatment endorses quality care, medical necessity, and cost effectiveness. Under these circumstances any such alternative treatment will be covered by the Plan, if approved by the plan administrator.

CONTRIBUTIONS

As dictated by individual employer's collective bargaining agreements and/or policies, the employers may require a portion of the cost of the Plan to be funded by employee and/or retiree contributions.

INCORPORATION OF SUMMARY PLAN DESCRIPTION

The attached Summary Plan Description is hereby incorporated in and made a part of this Plan Document. It is agreed by the Plan Administrator that claims presented under this Plan will be paid according to the provisions of this Plan Document.

SUMMARY PLAN DESCRIPTION

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SUMMARY PLAN DESCRIPTION INTRODUCTION

SUMMARY PLAN DESCRIPTION OVERVIEW

This document is a Summary Plan Description of the Health Benefits of the Greater Tompkins County Municipal Health Insurance Consortium. It is designed to give enrollees a general outline of the plan provisions and to help enrollees understand the details of the Plan. It explains the benefits, the eligibility requirements and termination of coverage. This document should be read carefully to become familiar with a covered person's rights, responsibilities, and the benefits. This document replaces any and all previously issued plan documents, summary plan descriptions, booklets, certificates, or other documents. It is suggested that a copy of this document be kept it in a convenient place for future use as a reference.

Every attempt has been made to be informative about the benefits available under the Plan, and those areas where a benefit may be lost or denied.

The benefits described herein are subject exclusively to the provisions and limitations of the Plan Document, which incorporates this Summary Plan Description by reference. Where a question may arise as to a claim for benefits or a denial of a claim for benefits, the Plan Administrator, and such other individuals who may be party to or associated with the Plan, shall be guided solely by the Plan Document (including the terms and provisions of this Summary Plan Description). A copy of the formal Plan Document (including this Summary Plan Description) will be kept on file at each participating municipality's business office.

The benefits described in this Summary Plan Description are in effect as of TBD

PLAN COSTS

The Greater Tompkins County Municipal Health Insurance Consortium is a self-funded plan. Contributions from the participating municipalities, and payroll deductions from covered employees and retirees go into the Greater Tompkins County Municipal Health Insurance Consortium Benefit Account; benefits are paid out of that account. The Plan is administered by the Plan Administrator, which processes all claims and makes benefit payments.

GENERAL INFORMATION

Plan Name

The Greater Tompkins County Municipal Health Insurance Consortium's Indemnity Plan.

The Name, Business Address and Telephone Number of the Plan Administrator

Excellus BlueCross BlueShield of the Central New York Region
333 Butternut Drive
Syracuse, NY 13214-1803
(877) 757-3850

The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable law.

The Plan Administrator may, by written instrument, allocate and delegate its fiduciary responsibilities.

The agent for service of legal process is the Attorney-in-Fact designated by the Board of Directors of the Plan. The name and address of the Attorney-in-Fact are available from the Plan Administrator at the address and telephone number above.

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described herein.

Type of Plan

Group Health Benefits Plan

Type of Administration

Contract Administration

The Sources of Contributions to the Plan

Employer, Employee, and Retiree contributions

Plan Year

The financial records of the Plan are maintained on the basis of a plan year commencing on January 1 and ending on December 31.

ELIGIBILITY

ELIGIBLE EMPLOYEES

An employee of a participating municipality, and the employee's dependent(s), must be offered the opportunity to enroll in the Plan subject to the following:

The employee works a regularly scheduled work week of 20 hours or more; or

The employee works a scheduled work week of less than 20 hours and:

The employee earns the minimum wage established by the employer's personnel policies and/or Collectively Bargaining Agreements to qualify for benefits; and

The employee's major source of family income is from public employment. (An employee in such a case does have the burden of proof and must submit such proof to the plan administrator.)

An employee who does not meet the eligibility requirements outlined above at the time of his/her employment may later acquire eligibility by virtue of a change in his/her employment conditions. In such cases the first day of eligibility for enrollment will be the date on which the employment status change occurs.

If the regularly scheduled work week of an enrolled employee is reduced to less than 20 hours, by resolution an individual participating municipality's governing body may grant extensions not exceeding one year each during which such enrolled eligibility will continue.

Waiting Period

A newly hired employee of a participating municipality is not required to wait a period of time before s/he can enroll in the Plan.

Late Enrollment

If an employee does not apply for coverage on behalf of his/her self and his/her eligible dependents within the first three months after the date of employment, or other date of eligibility for such coverage, it may be necessary for the employee or dependents to satisfy a waiting period before coverage can become effective.

This waiting period applies to any services rendered within three months of the effective date of coverage for individuals who enroll beyond their original date of eligibility. This exclusion only applies during the first eleven (11) months of coverage. However, this benefit exclusion will not supersede the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). Specifically, the late enrollment exclusion is limited by the following:

- The time that a covered person was covered under any other health insurance or HMO contract or policy or employer-provided health benefit arrangement providing creditable coverage as defined by HIPAA before the covered person became covered under the Plan will be counted toward the waiting period, if there was not a break in coverage greater than 63 days between the termination of the previous coverage and the covered person's enrollment under the Plan. In the case of previous coverage, any HMO affiliation period before coverage becomes effective under the Plan shall be considered as time covered for purposes of providing credit for previous coverage.

Late Enrollment (Cont.)

Creditable coverage includes: coverage provided through health insurance; self-insured group health benefit plans; Medicaid; Medicare; government-sponsored health benefit programs, such as CHAMPUS, Peace Corps, or Indian Health Service; the Federal Employees Health Benefits Program; a state health benefits risk pool; or any health insurance plan sponsored by a state, county or other political subdivision.

The covered person has the right to obtain a certificate from the employer, insurer, HMO or governmental health benefit plan that provided the prior creditable coverage. The certificate will enable the covered person to demonstrate the prior creditable coverage that will be counted toward fulfillment of the waiting period under the Plan. Contact the plan administrator for help in obtaining a certificate for prior creditable coverage

- The late enrollment exclusion does not apply to: (1) services associated with pregnancy; (2) newborn or newly adopted children; or (3) genetic information, including gene products; inherited characteristics that may derive from the individual or family member, including information regarding carrier status and information derived from lab tests that identify mutations in specific genes or chromosomes; physical medical examinations; family histories; and direct analysis of genes or chromosomes.

Supplemental Suspension, Continuation, and Conversion Rights for Armed Forces Reservists on Active Duty

If an employee is a member of a reserve component of the armed forces of the United States, including the National Guard, and the employee enters active duty but the employee's participating municipality does not voluntarily maintain the employee's coverage under the Plan, coverage will be suspended unless the employee elects, in writing, to the participating municipality, within 60 days of being ordered to active duty, to continue coverage under the Plan for the employee and eligible dependents. Such continued coverage shall not be subject to evidence of insurability. The employee must pay the required group rate premium in advance to the participating municipality, but not more frequently than once a month.

Supplementary continuation coverage shall not be available to any person who is, or could be, covered by Medicare of any other group coverage. Coverage available through the federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this section.

In the event that an armed forces reservist is re-employed or has his/her eligibility status restored by the participating municipality upon returning to civilian status after the period of continuation coverage or suspension, the reservist (and covered dependents, if any) shall be entitled to resume coverage under the Plan. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty, provided that the applicable premium has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage, except regarding:

- A condition that arose during the period of active duty and that has been determined by the secretary of veterans' affairs to be a condition incurred in the line of duty;

- A waiting period imposed that has not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed 11 months;

Supplemental Suspension, Continuation, and Conversion Rights for Armed Forces Reservists on Active Duty (Cont.)

- In the event that the reservist is not re-employed or restored to eligibility upon return to civilian status, s/he shall have the right, within 31 days of the termination of active duty, or discharge from hospitalization incident to active duty that continues for a period of not more than one year, to submit a written request for continuation to the participating municipality, or a request for conversion through the participating municipality, as described elsewhere in the Summary Plan Description. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If other than individual coverage applies, and supplementary continuation coverage is elected or if coverage is suspended, the supplementary conversion right shall be available to the spouse, if divorce or annulment of the marriage occurs during the period of active duty. In the event of death while on active duty, the supplementary conversion right shall be available to the spouse and children covered under the Plan, and to each child individually upon attaining the maximum age for coverage under the Plan.

Date of Coverage

The date coverage becomes effective for employees and all eligible dependents will occur on the first day of the month following the month in which the enrollment form is received by the plan administrator. An employee's dependent becomes eligible for enrollment on the date s/he first becomes the dependent of the enrolled employee.

When Coverage Begins

Coverage will begin when an employee has satisfied any required waiting period, and is enrolled in the Plan. An employee will be deemed to have enrolled when a completed and signed Enrollment Form has been received by the plan administrator along with any required contributions. An enrollment form must be completed within 31 days of the date an employee is first eligible or within 31 days of a qualifying event.

Retiree Eligibility

An employee may continue benefits after retirement by making contributions, if required by the participating municipality, and meeting the requirements as set forth in their Collective Bargaining Agreements, Personnel Policies and/or Legislative Resolutions.

Survivor's Coverage

An employee's spouse and/or dependent children may be able continue benefits after the employee's death by making contributions, if required by the participating municipality, and by meeting the requirements as set forth in their Collective Bargaining Agreements, Personnel Policies and/or Legislative Resolutions.

The coverage of dependent children may be continued for so long as the children would have been eligible had the enrollee lived. No application for this continuation of coverage will be accepted more than 90 days after the date of death of the employee or retired employee.

The ten years necessary to qualify for survivor spouse coverage may be with a combination of employment by any of the following:

The participating municipality;
The State of New York; and
Any political subdivision of the State of New York.

The benefits of this section are in addition to, and not in place of, the continuation and conversion benefits provided elsewhere in the Summary Plan Description.

ELIGIBILITY

DEPENDENT COVERAGE
Coverage is provided for the following dependents:
Legal spouse (includes legally separated but not divorced spouse).

Legal spouse also includes the spouse of marriages of same sex partners legally performed in New York State as well as other jurisdictions since New York now recognizes same sex marriage.

Domestic Partners

Dependent coverage is extended to domestic partners under this policy/certificate. Proof of the domestic partnership and financial interdependence must be submitted to us in the form of:

A. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or

B. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

1. The affidavit must be notarized and must contain the following:
    - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
    - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
    - The partners have been living together on a continuous basis prior to the date of the application; and
2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
3. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
    a. A joint bank account
    b. A joint credit card or charge card
    c. Joint obligation on a loan
    d. Status as an authorized signatory on the partner's bank account, credit card or charge card
    e. Joint ownership of holdings or investments
    f. Joint ownership of residence
    g. Joint ownership of real estate other than residence
    h. Listing of both partners as tenants on the lease of the shared residence
    i. Shared rental payments of residence (need not be shared 50/50)
    j. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
    k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
    l. Shared household budget for purposes of receiving government benefits
    m. Status of one as representative payee for the other's government benefits
    n. Joint ownership of major items of personal property (e.g., appliances, furniture)
    o. Joint ownership of a motor vehicle

p. Joint responsibility for child care (e.g., school documents, guardianship)

q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)

r. Execution of wills naming each other as executor and/or beneficiary

s. Designation as beneficiary under the other's life insurance policy

t. Designation as beneficiary under the other's retirement benefits account

u. Mutual grant of durable power of attorney

v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney)

w. Affidavit by creditor or other individual able to testify to partners' financial interdependence

x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.

Newborn children and/or newly born infants adopted by the member:
Coverage will be effective for newborn children and newly born infants adopted by a member from the moment of birth for policies currently covering families (Not individual or two persons coverage). For newly adopted infants, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage for the infant's care.

Coverage will be afforded to newborns and newly born infants adopted by the member from the moment of birth if the member provides the proper notification and premium adjustments within 31 days of the birth. .
Infants not enrolled under the contract within 31 days of birth, will be covered from the time notice is given.

Children (natural or legally adopted, or pre-adopted) who are under the age of 26:

Coverage lasts until the end of the month in which your child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as a full time student; or unmarried.

Children-in-law (spouses of children) and grandchildren are not covered.

Children who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who:

Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

Became so incapable prior to attaining age 26. Coverage shall not terminate while this contract remains in effect and the child remains in such condition.

Proof of your child's incapacity must be submitted within 31 days of your child's attaining age 26.

ELIGIBILITY

"Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

Young Adult Option:

Coverage for a dependent child who loses coverage by reason of age or student eligibility may be able to have coverage extended through age 29.

Parent:
To qualify for this "Age 29" benefit, the **parent** must be covered under the policy or pursuant to a right under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation coverage law.

Young Adult:
The Young Adult must be unmarried; be 29 years of age or younger; not be insured by or eligible for comprehensive (i.e. medical and hospital) health insurance through his or her own employer; must live, work or reside in New York State or the health insurance company's service area and is not covered by Medicare. The child may purchase coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

Premium – Cost of coverage:
The young adult or his or her parent will be responsible for a separate premium for the young adult option (over and above what the parent pays for the group coverage).

Your Child may Elect this Coverage:
1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;

2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment;

3. During an annual 30-dy open enrollment period, in which case coverage will be prospective and will start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment; and

4. During an initial 12-month open enrollment period, commencing on the first renewal of the policy on or after September , 2009, in which case coverage will be prospective and start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment.

If the covered person applies for coverage on behalf of a dependent whose last name differs from his/hers, other than a married spouse or natural child, the covered person needs to submit to the plan administrator a statement of dependence that must be reviewed and accepted by the plan administrator prior to the dependent's enrollment in the Plan.

ALL OTHER PERSONS ARE EXCLUDED FROM COVERAGE UNDER THIS PLAN.

ELIGIBILITY

When Dependent Coverage Stops

Dependent coverage normally stops when the dependent fails to meet any of the coverage requirements as listed in this document. When coverage for a dependent ends, the dependent will have an opportunity to obtain continuation of medical coverage, at his or her own cost, as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) and New York State law. For more information on the right to continue medical coverage under COBRA and New York State law, see the section entitled CONTINUATION OF COVERAGE.

Ineligible Dependents
In no event will an individual be a dependent under the Plan if enrollment is attempted after a covered person's retirement, unless dependent status occurs after the covered person's retirement, subject to the HIPPA exceptions set forth in the Section entitled LATE ENROLLMENT.

Extension of Coverage for Dependents
Coverage may continue for a dependent child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the New York State Mental Hygiene Law; or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate, and who is chiefly dependent upon the covered person for support and maintenance and who is unmarried, after attaining the age when coverage would normally terminate, subject to the covered person's own coverage continuing in effect.

To continue a dependent child's coverage beyond that time, proof of his/her incapacity must be submitted to the plan administrator within 31 days from the date of your dependent's attainment of the termination age. Proof of the incapacity will be required from time to time to keep this coverage in effect. Determination of dependent eligibility is solely the responsibility of the plan administrator.

This continuation stops on the earliest of the following dates:

The date on which the dependent is no longer incapacitated according to the plan administrator;
The date proof of the dependent's incapacity is not provided at the request of the plan administrator;
The date the dependent's coverage stops because of another Plan provision.

Enrolling Dependents
An employee may enroll for family coverage at the time of eligibility for individual coverage. Necessary enrollment forms must be completed within 31 days of the date the dependent is first eligible.

Enrollment Changes
A covered person may change benefit coverage during an open enrollment period which will be offered at least once annually as determined by the participating municipality, or at the time of a change in family status such as:

Marriage or divorce;
Birth, adoption, or pre-adoption;
Death of a spouse or a child;
Loss of group insurance by spouse.

Adopted Children
Coverage of adopted children is not conditional upon the finalization of adoption proceedings, but is effective when the child is placed with a covered person for adoption. No restriction will be placed upon this child regarding pre-existing conditions.

ELIGIBILITY

A "child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" or "being placed for adoption" means (in connection with adoption proceedings) the assumption and retention by a covered person of the legal duty for the total or partial support of a child to be adopted. The child's placement with such person terminates whenever the legal duty likewise terminates.

PROVISIONS RELATED TO QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Purposes

The Plan Administrator has adopted the following procedures for determining whether medical child support orders are qualified. The Plan Administrator has also adopted these procedures to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. The Plan Administrator may alter, amend, or terminate these procedures and substitute alternative procedures to satisfy legal requirements.

Definitions

For purposes of the QMCSO requirements the following definitions apply. A Qualified Medical Child Support Order means a medical child support order that creates or recognizes an alternate recipient's right to receive benefits for which a covered person is eligible under the Plan, and that it has been determined by the plan administrator to meet the qualification requirements of these procedures.

Medical Child Support Order means any court judgment, decree or order (including approval of settlement agreement) which:

Provides for child support for a child of a covered person under a group health plan, or
Provides for health coverage to such a child under state domestic relations law (including a community property law), and
Relates to benefits under this Plan.

Alternate Recipient means any child of a covered person who is recognized under a Medical Child Support Order as having a right to enroll in a group health plan with respect to the participant.

Qualified Medical Child Support Order (QMCSO)

A Medical Child Support Order to be qualified must clearly:

Specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order;

Include a reasonable description of the type of coverage to be provided by the Plan to each alternative recipient, or the manner in which such type of coverage is to be determined;

Specify each period to which such order applies; and

Specify each plan to which such order applies.

A Medical Child Support Order to be qualified must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirement described

in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

ELIGIBILITY

Procedures

Upon receipt of a Medical Child Support Order the Plan Administrator shall:

Promptly notify the participant in writing, each alternative recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.

Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order.

Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the appropriate parties of such determination.

Ensure the alternate recipient is treated by the Plan as a beneficiary for reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

Medicare Eligibility

Details pertaining to Medicare eligibility can be found in this Plan Document under the section titled Medicare Eligible Employee Coverage.

The Plan has contracted with a group of Physicians, Hospitals, and other Ancillary Providers who may be used by covered persons to provide covered services described in this Summary Plan Description. A list of the participating providers is included with your enrollment packet and is available on-line at the Excellus BCBS web site of www.excellusbcbs.com. Additional copies of the provider directory or questions about specific providers may be obtained by contacting the Excellus BCBS Customer Service Department at: 1-800-499-1275. Upon enrollment in the Plan, covered persons will receive information describing how to access the list of participating medical providers and facilities. Please note, each individual participating municipality has not contracted directly with any health professional nor do they promote one health professional over another.

A covered person under this Plan is eligible to receive care from any participating provider. It is recommended that a member verify a provider's participation prior to seeking services by contacting the plan administration.

Utilization of participating providers is totally voluntary. However, if a participating provider is used, a covered person will realize the following advantages:

Participating providers will always accept payment for covered services directly from the Plan.

A covered person will not be billed for the balance of any covered services in excess of the applicable co-payment, deductible, or co-insurance amounts as specified in this document.

The out-of-pocket costs for covered services provided by a participating provider normally will be less than the out-of-pocket costs for the same services provided by a nonparticipating provider.

There are separate payment levels under this Plan for participating and nonparticipating providers. The benefits for participating providers are generally higher than those for nonparticipating providers. The benefit amounts and limits with respect to covered services by both participating and nonparticipating are shown in the section entitled BENEFIT SUMMARY.

A participating provider has an agreement with the Plan to accept payment for covered services based on a predetermined fee schedule. Therefore, a covered person will not be responsible for any charges, other than applicable co-payments, which exceed the participating provider's fee schedule. When a nonparticipating provider is used the covered person is responsible for the deductible, 20% coinsurance, and any provider charges that are in excess of the Allowable Expense.

DEDUCTIBLES/COINSURANCE

Covered persons must pay applicable deductibles and coinsurance as outlined in the Benefit Summary Section for certain services before benefits are payable. There are maximum family Deductibles and Out of Pocket expenses.

OUT-OF-AREA COVERAGE

For out-of-area services, the Plan has contracted with large national provider network(s), to provide the covered person with the opportunity to receive in-network benefits for services performed in areas not within the Greater Tompkins County Municipal Health Insurance Consortium. If there are no in-network participating providers, or if there are not the appropriate in-network specialists in the area in which a covered person seeks service, in-network benefits shall be available at the discretion of the Plan Administrator.

To ensure access to in-network benefits, a listing of participating providers and facilities in a specific area will be forwarded upon request to the covered person by contacting the plan administrator at (877) 757-3850. If there are no participating providers or facilities in a specific area, a covered person shall be granted authorization for in-network benefits verbally by the plan administrator. Written authorization will be issued to the covered person within two (2) business days.

OUT-OF-AREA COVERAGE (Cont.)

If emergency care is required, a covered person should seek appropriate care or services directly as needed. Emergency care will be treated as an in-network benefit regardless of the status of the facility as a participating or non-participating facility.

OUT-OF-NETWORK DEDUCTIBLE & COINSURANCE

To be eligible for reimbursement, a covered person is required to meet the deductible for out-of-network, medically necessary covered services. The deductible amount applies separately to the covered person and to each of his/her covered dependent(s), subject to any family maximum deductible as set forth in section entitled BENEFIT SUMMARY. Covered expenses that apply toward the deductible amounts are the Allowable Expense amount, or charges, whichever is less. Covered expenses which are used in satisfying the deductible amount must be incurred and applied to such deductible within the applicable calendar year.

For any amounts in excess of the deductible amount as set forth in the section entitled BENEFIT SUMMARY, the Plan will pay for such excess in accordance with the coinsurance provision set forth in the section entitled BENEFIT SUMMARY, subject to all the provisions which follow.

The deductible amount must be satisfied once each calendar year except for:

The Carryover Provision - If any part of the deductible amount has been satisfied during the last three months of a calendar year for services rendered in the last three months of that calendar year, the deductible amount for the next calendar year will be reduced by that amount.

The Common Accident Provision - If two or more members of one family incur covered expenses because of injuries sustained in any one accident, the deductible amount will be applied only once with respect to all covered expenses incurred as a result of the accident.

OUT-OF-POCKET MAXIMUMS

The benefit payment for covered services that are subject to coinsurance will increase to 100% of the Allowable Expense, less any applicable deductible for each covered person during the calendar year, after:

The covered person pays a total of the out-of-pocket maximum amount as set forth in the section entitled BENEFIT SUMMARY, in coinsurance amounts for out-of-network covered services; or

The family pays a total of the out-of-pocket maximum amount as set forth in the section entitled BENEFIT SUMMARY, in coinsurance amounts for out-of-network covered services. The out-of-pocket maximum amount applies separately to the covered employee and to each of his/her dependent(s), subject to any family maximum as set forth in the Benefit Summary. A family can meet its family out-of-pocket maximum amount even if no individual meets the individual out-of-pocket maximum amount.

Only the coinsurance amounts that a covered person pays towards covered services count towards the out-of-pocket maximum amount. Any other deductibles, in-network co-payments, prescription drug co-payments, or amounts that the covered person pays to a non-participating provider in excess of the Allowable Expense will not count toward the individual or family out-of-pocket maximum amounts.

ALLOWABLE EXPENSE

"Allowable Expense" means the maximum amount we will pay to a Professional Provider for the services or supplies covered under this Certificate. We determine our Allowable Expense as follows:

(1) The Allowable Expense for covered services received for a Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense for Participating Providers will be the amount we have negotiated with the Facility or the amount approved by another Blue Cross and Blue Shield Plan: and the Allowable Expense for Non-Participating Providers will be 100% of the provider's charge.

(2) The Allowable Expense for covered services received from Participating Professional Providers will be the amount we have negotiated with the provider or the amount approved by another Blue Cross and Blue Shield Plan; and the Allowable Expense for Non-Participating Providers will be the lower of : the national Medicare fee schedule amount for the Calendar Year prior to the Calendar Year in which the services are rendered or the provider' charge.

(3) The Allowable Expense for services rendered by Non-Participating Providers in connection with an Emergency Condition is the provider's charge.

MAXIMUM BENEFIT

The amount payable under the Plan for all covered medical expenses incurred by any covered person during the maximum benefit period as set forth in the section entitled BENEFIT SUMMARY shall not exceed the applicable maximum benefit specified in the section entitled BENEFIT SUMMARY.

WEEKEND ADMISSION EXCLUSION

If a covered person is admitted to a hospital on Friday or Saturday, the hospital daily room and board charges for that day will NOT be covered if the covered person does not receive any treatment, therapy, or surgery requiring hospitalization on the day of the admission, or if the admission is an elective admission.

TRANSITION OF CARE

Should a participating provider leave the network, provisions exist to give the affected covered persons time to transition to a different health provider should they wish to continue to receive in-network benefits. If the health provider is a primary care physician (i.e. internist, family practitioner, general practitioner, OB/GYN, pediatrician), the covered person shall receive up to four (4) months of services from the withdrawing physician subject to in-network benefits. If the health provider is a specialist, the covered person shall receive the remainder of the treatment pattern subject to in-network benefits.

Should a health provider leave the network, the Plan shall make every effort to notify the enrollees.

BENEFIT SUMMARY

*** **THIS SECTION PROVIDES A SUMMARY OF THE PLAN BENEFITS. PLEASE BE SURE TO REFER TO ALL APPROPRIATE SECTIONS IN THIS SUMMARY PLAN DESCRIPTION FOR A COMPLETE DESCRIPTION OF THE BENEFITS PROVIDED BY THE PLAN. IN PARTICULAR, PLEASE REFER TO THE SECTIONS TITLED "WHAT THE MEDICAL PLAN COVERS" AND "WHAT THE MEDICAL PLAN DOES NOT COVER".**

Eligibility Please refer to the eligibility section of this Summary Plan Description for a complete description of who is eligible and when they are eligible for coverage.

Pre-Existing There is no exclusion for pre-existing conditions. However, a waiting period for late enrollment may apply. See the Section entitled LATE ENROLLMENT (Page 8-9).

Allowable Expense (AE) For any services performed by an out-of-network provider, the covered person is responsible for any charges in excess of the Allowable Expense (AE). The Plan has set the Allowable Expense at the lower of: the national Medicare fee schedule amount for the Calendar Year prior to the Calendar Year in which the services are rendered; or the provider's charge, whichever is less. Because of this, the Plan strongly encourages individuals to discuss, in advance, whenever possible, with out-of-network providers, the cost of their services. The plan administrator will be able to assist in determining the amount, if any, of the charges that are in excess of the Allowable Expense (AE). Please see Page 19 for further information about the Allowable Expense.

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Allergy Treatment		
Office Visit	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance
Injection Only	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance
Ambulance (Including professional and volunteer)		
	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance
Ambulatory Surgery (Including outpatient surgery)		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Anesthesia (In and outpatient)		
The Plan pays:	100%	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Assistant Surgeon		
The Plan pays:	100%	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Autism Spectrum Disorder	(Per New York State mandate the Plan will provide coverage for Medically Necessary services for the diagnosis and treatment of autism spectrum disorder subject to the definitions and conditions listed under "Autism Spectrum Disorder" in the **"What the Medical Plan Covers**" section of this document.) The Plan's payment for In-Network and Out of Network services will be subject to the same cost sharing that applies to similar medical benefits under this Plan Document.	
Diagnostic lab, x-ray, surgery		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Office/Home Visits	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	20% coinsurance	20% of AE amount and any remaining balance
Cervical Cytology - Routine	(Pap smear – including exam)	
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Chemical Dependence		
Inpatient	Same as Health Benefit	
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Outpatient		After deductible
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Chiropractic Care	(Benefit limited to medical necessity)	
	After deductible	After deductible
The Plan pays:	80% off contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT

Dental (Dental services covered for injury and for treatment of a congenital disease or anomaly only)
(Oral Surgery services are covered for the removal of bony impacted or soft tissue impacted teeth, operative procedures involving the gum tissue and reduction fractures)

	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance

Diabetic Supplies (Includes educational and nutritional counseling as per the state mandate)
(State mandated supplies covered under medical, other supplies covered under Rx Plan)

	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance

Diagnostic Lab and X-ray (Includes bone mineral density testing and diagnostic services related to infertility, as per state mandate and as defined and listed under "What the Medical Plan Covers").

		After deductible
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Dialysis

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Durable Medical Equipment (Including orthotic devices)

	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/Coinsurance	20% of AE amount and any remaining balance

Emergency Services

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	any remaining balance

Gynecology (Routine exam including pap smear, limited to one per calendar year)

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT

Home Health Care

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Hospice Care (Care for terminally ill; benefit limited to 210 days maximum per lifetime - bereavement counseling limited to the immediate family of the hospice patient and is limited to five days)

The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	$0.00	20% of AE amount and any remaining balance

Hospital Emergency Room Care (The New York State emergency care mandate applies to this benefit)

The Plan pays:	100%	100%
The covered person pays:	$0.00	$0.00

Hospital Room & Board

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Infertility Services (Per New York State mandate the Plan will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the definitions and conditions listed under "Infertility Services" in the "What the Medical Plan Covers" section of this document.)

The Plan's payment for In-Network and Out of Network services will be subject to the same cost sharing that applies to similar medical benefits under this Plan Document.

Diagnostic lab, x-ray, surgery

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Office/Home Visits	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	20% coinsurance	20% of AE amount and any remaining balance

Mammograms (Routine) (Per physician recommendation, and/or routine mammograms covered once every calendar year for ages 35 and over)

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Maternity (Including prenatal, delivery, and post-partum care)
(This benefit is for the physician's services)

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Birthing Center and Midwife

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Medical Supplies	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	20% of contracted rate	20% of AE amount and any remaining balance
Newborn Baby Care (Facility and professional charges)		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Organ/Tissue Transplants		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Physician Services		
INCLUDES:		
Office/Home Visits	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	20% coinsurance	20% of AE amount and any remaining balance
Diagnostic X-ray/Labs		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Inpatient Hospital Visit (Benefit limited to one visit per day)		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Inpatient Consultation (Benefit limited to one visit per day)		
The Plan pays:	100% of contracted rate	100% of AE amount
Physician Services (Con't)		
Inpatient Hospital Visit (Benefit limited to one visit per day)	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	20% coinsurance	20% of AE amount and any remaining balance
Inpatient Consultation (Benefit limited to one visit per day)		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance
Podiatry	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/coinsurance	20% of AE amount and any remaining balance
Pre-Admission Testing (Must be done within 7 days prior to admission)		
The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT

Prescription Drugs (Includes coverage for infertility prescription drugs, contraceptives and orally administered cancer drugs** as defined and listed under "**What the Medical Plan Covers**" section of this document).

Retail Pharmacy (limited to a 30 day supply):

Tier 1 (Generic Medications):	The covered person pays: $1.00
Tier 2 (Preferred Brand Name Medications)	The covered person pays: $1.00
Tier 3 (Non-Preferred Brand Name Medications	The covered person pays: $1.00)
Contraceptive drugs and devices	The covered person pays: $0.00

Mail-Order Pharmacy (typically a 90 day supply):

Tier 1 (Generic Medications):	The covered person pays: $0.00
Tier 2 (Preferred Brand Name Medications:	The covered person pays: $0.00
Tier 3 (Non-Preferred Brand Name Medications:	The covered person pays: $0.00
Contraceptive drugs and devices	The covered person pays: $0.00

**Orally administered cancer drugs –Cost sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost sharing amount or the Cost sharing amount, if any, that applies to intravenous or injectable chemotherapy agents.

Preventive Care – see what the Medical Plan covers for additional information on Preventive Services

Adult Routine Physical Exams (Benefit limited to one exam every calendar year)

The Plan pays:	100% of contracted rate	Not Covered
The covered person pays:	$0.00	

Well-Child Care (up to the 19th birthday including immunizations) (as per the Advisory Committee on Immunization Practices (ACIP) Guidelines):

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	$0.00

Prosthetic Devices

	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/coinsurance	20% of AE amount and any remaining balance

Psychiatric Benefits

Inpatient (Same as Health Benefit)

The Plan pays:	100% of contracted rate	100% of AE Amount
The covered person pays:	$0.00	Any remaining balance

Outpatient	After deductible	After deductible
The Plan pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/coinsurance	20% of AE amount and any remaining balance

These benefits will be subject to the same cost sharing that applies to similar medical benefits under this Plan Document.

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT

Second Medical Opinion (Cancer Related) (Not mandatory, at patient's prerogative)

The Plan pays	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Second Surgical Opinion (Not mandatory, at patient's prerogative)

The Plan pays	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Skilled Nursing Facility Care (Benefit limited to 365 days per calendar year maximum)

The Plan pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Surgery: Physician's Charge (Inpatient and Outpatient)

The Plan Pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Therapy including (but not limited to):

Cardiac Infusion Respiratory Chemo Oxygen Physical Radiation Respiratory
Diabetes - limited to state mandated benefit

Above services are all subject to the following:

The Plan Pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Therapy (Speech):

Inpatient

The Plan Pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Outpatient	After deductible	After deductible
The Plan Pays:	80% of contracted rate	80% of AE amount
The covered person pays:	Deductible/coinsurance	20% of AE amount and any remaining balance

Urgent Care Center

The Plan Pays:	100% of contracted rate	100% of AE amount
The covered person pays:	$0.00	Any remaining balance

Exclusions:	See the section entitled GENERAL EXCLUSIONS SECTION in this Summary Plan Description for further details.		
Deductible:	Individual:	$ 50	$ 50
	Family:	$ 150	$150
Out-of-Pocket Maximum:			
	Individual:	$ 400.00	$ 400.00
	Family:	$1,200.00	$1,200.00

Services which do not count toward fulfilling the deductible or out-of-pocket expenses include: in-network co-payments, prescription drug co-payments, or any payments in excess of the Allowable Expense amount.

Lifetime Individual Maximum Benefit in-network and out-of-network combined:	Unlimited
Annual Individual Maximum Benefit in-network and out-of-network combined:	Unlimited

Please Note: The phrase "the Plan pays the allowable amount" refers to the medically necessary covered services and supplies that are eligible for benefits, subject to the benefits, limitations, and exclusions outlined throughout this Summary Plan Description. For in-network services, the allowable amount is the contracted rate less any deductible and coinsurance. For out-of-network services, the allowable amount is the AE amount less any deductibles and coinsurances. The cost sharing component between the Plan and the covered person is defined in the section entitled BENEFIT SUMMARY of this Summary Plan Description.

Allergy Treatment

The Plan pays the allowable amount for medically necessary allergy testing, injections and treatment material.

Ambulance Transportation

The Plan pays the allowable amount for local ambulance service. The Plan pays the allowable amount for hospital professional ambulance or a volunteer professional ambulance that charges for its services. Coverage is limited to medically necessary transportation to and from the nearest hospital that can give necessary care and treatment. This benefit also includes an air ambulance when it is determined to be medically necessary.

Ambulatory Services and Supplies

The Plan pays the medically necessary, allowable amount for the following:

Tests ordered by the surgeon before surgery if:

Proper diagnosis and treatment require the tests;
Surgery has been scheduled before the tests;
The covered person is present at the center for the tests; and
The tests are billed by, and payable to, the ambulatory surgery center or hospital.

Services and supplies furnished on the date of the procedure by the ambulatory surgical center or hospital.

Services of the operating physician for performing the procedure, for related pre- and post-operative care, and for the administration of anesthesia.

Services of any other physician for the administration of anesthesia, excluding local anesthesia.

Limitations and/or Exceptions

No benefit is paid for charges incurred:

For the services of a physician who renders technical assistance to the operating physician unless required in connection with the procedure; or

While the person is confined as a full-time inpatient in a hospital

Ambulatory Surgery Benefit

The Plan pays the medically necessary allowable amount for an ambulatory surgical center, or the outpatient department of a hospital, for outpatient services and supplies furnished in connection with the performance of a surgical procedure. The procedure must meet the following criteria:

Ambulatory Surgery Benefit (Con't)

It is not expected to:

Result in extensive blood loss;
Require major or prolonged invasion of a body cavity;
Involve any major blood vessels; or
Normally be performed in the office of a physician or a dentist.

Ancillary Services

The Plan pays the allowable amount for medically necessary ancillary services.

Anesthesia Benefit

The Plan pays the allowable amount for the medically necessary administration of anesthetics by a physician or registered nurse anesthetist (R.N.A.), under the direct supervision of a physician, during a covered surgery or maternity service at an inpatient or outpatient facility. One payment includes the consultation before anesthesia service is given and the provider's services during and after surgery or maternity services.

Assistant Surgeon Benefit

The Plan pays the allowable amount for medically necessary professional services of a physician to render technical assistance to the operating surgeon when required in connection with a performed surgical procedure. However, no benefits are payable for surgical assistance rendered in hospitals where it is routinely available as a service provided by a hospital intern, resident, or house officer. The assistant surgical allowance is determined by using 20% of the surgeon's fee allowance or AE amount.

Autism Spectrum Disorder

We cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis and treatment of Autism Spectrum Disorder. For purposes of this benefit, "Autism Spectrum Disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PPD-NOS).

- **Screening and Diagnosis** – we cover assessments, evaluations and tests to determine whether someone has autism spectrum disorder.

- **Assistive Communication Devices** – we cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we cover the rental of purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if you are unable to communicate through normal means (i.e. speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or speech-generating devices. Installation o the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Autism Spectrum Disorder (con't)

Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment or theft are not covered. Coverage will be provided for the device most appropriate to your current functional level.

- **Behavioral Health Treatment –** We cover counseling and treatment programs that are necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We cover applied behavior analysis when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Our coverage of applied behavior analysis services is limited to 680 hours per member plan year.

- **Psychiatric and Psychological Care –** we cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the insurance law, licensed in the state in which they are practicing.

- **Therapeutic Care –** We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under tis policy. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this policy.

- **Pharmacy Care –** We cover prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription Drug Benefits under this policy.

We will not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the policy for service provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable, Deductible, Copayment, or Coinsurance provisions under this policy for similar services. For example, any Deductible, Copayment or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this benefit; and any Deductible, Copayment or Coinsurance for Prescription Drugs generally will also apply to prescription drugs covered under this benefit. Any Deductible, Copayment or Coinsurance that applies to office visits will apply to assistive communication devices covered under this paragraph.

Autism Spectrum Disorder (con't)

Nothing in this policy shall be construed to affect any obligation to provide coverage for otherwise covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

Bereavement Benefits

The Plan covers bereavement services for the immediate family only of a hospice patient and is limited to 5 visits.

Blood and Blood Plasma (Including Blood Transfusions)

The Plan pays the allowable amount for medically necessary blood, blood plasma and blood plasma expanders when not replaced by or for the patient.

Bone Density Testing – See Preventive Services in this section for additional information

The plan pays for bone mineral density measurements and tests for the detection of osteoporosis. The Plan will apply the standards and guidelines that are consistent with the criteria of the Federal Medicare program or the National Institute of Health (NIH) to determine appropriate coverage for bone density testing under this Section of the Plan Document. Coverage will be provided for tests covered under Medicare or consistent with NIH criteria including, as consistent with such criteria, dual-energy x-ray absorptiometry. When consistent with Medicare or NIH criteria, coverage, at a minimum, will be provided for those covered persons:

Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or
On a prescribed drug regimen posing a significant risk of osteoporosis; or
With lifestyle factors to the degree of posing a significant risk of osteoporosis; or
With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

Cardiac Rehabilitation Services (Therapy)

The Plan pays the allowable amount for medically necessary physician recommended cardiac rehabilitation services from a health professional.

Chemical Dependence - Inpatient

The plan pays the allowable amount for the treatment of chemical dependence (including detoxification).

Inpatient covered services must consist of a 24 hour per day live-in program of services for the active treatment of chemical dependence. The program must be non-medical, except for detoxification, and must provide rehabilitation and treatment in a controlled environment. The treatment must be provided by trained, professional personnel. Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational or companionship nature. The services must be provided by an employee of the chemical dependence treatment facility. Benefit payments will not be made if the chemical dependence treatment facility turns the payments over to the person who provides the services.

To be eligible for inpatient chemical dependence care services, a covered person must be a registered inpatient and the stay must be determined to be medically necessary.

Chemical Dependence - Outpatient

The Plan pays the allowable amount for medically necessary outpatient treatment of chemical dependence.

The person in need of treatment is a covered person;

The family members receiving therapy are covered persons; and

No more than 20 family visits are used by all the family members combined.

Family therapy visits are available so that members of the patient's family may understand the illness and play a meaningful role in recovery. The payment for a family therapy session will be the same amount regardless of the number of family members who attend the family therapy session. Benefits will only be provided or one visit each day, except when a family therapy visit takes place on the same day that the patient has a visit separate from the family.

Benefits will not be provided for visits that consist primarily of participation in programs of a social, recreational or companionship nature.

In addition, coverage includes services furnished by a comprehensive health service organization, licensed or accredited hospital, community chemical dependence treatment facility, or other chemical dependence treatment clinics, and is licensed or approved to provide such services by the state where the services are rendered.

Chemotherapy

The Plan pays the allowable amount for the medically necessary services and medications, including orally administered medications, used for non-experimental treatment of malignant disease by chemical or biological anti-neoplastic agents. Cost sharing for orally administered anti-cancer drugs is the lesser of the applicable prescription drug cost sharing amount or the cost sharing amount, if any, that applies to intravenous or injectable chemotherapy agents.

Chiropractic or Manual Manipulation Care

The Plan pays the allowable amount for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Please note, this care must be medically necessary and not custodial in nature or for maintenance treatment, and must be within the scope of licensure of the health care professional.

Consultation Expense Benefit

The Plan pays the allowable amount for medically necessary services by a physician for consultation services, provided that the consultation services are asked for by the attending physician.

A "Consultation" consists of an examination of the patient, a review of his/her x-ray and laboratory examinations, and medical history. It must include a written report by the consulting physician if the attending physician requests one.

Diabetic Equipment and Supplies
Benefits are available only for a covered person with a diabetic condition. The Plan pays the allowable amount for the following equipment and supplies for the treatment of diabetic conditions:

Blood glucose monitors and control solutions;
Blood glucose monitors for the legally blind;
Testing products for glucose monitors, visual reading, and urine testing;
Injection aids;
Lancing devices;
Cartridges for the legally blind;
Syringes;
Alcohol swabs;
Data management systems;
Insulin pumps and appurtenances thereto;
Insulin infusion devices; and
Insulin and oral agents for controlling blood sugar.

Benefits will also be provided for additional designated diabetes equipment and supplies when required by a regulation of the New York State Commissioner of Health.

Diabetes Education

Benefits are available only for a covered person with a diabetic condition. The Plan pays the allowable amount for diabetes self-management education, which includes education relating to proper diet, as specified below, to ensure the patient is educated as to the proper self-management and treatment of the diabetic condition. Benefits will only be provided for self-management education when:

A covered person is initially diagnosed with diabetes;
A Physician diagnoses a significant change in the diabetic symptoms or condition that requires changes in self-management; or
It is determined that reeducation or refresher education is necessary.

The self-management education must be provided by:

A physician, nurse practitioner or staff member during an office visit for diabetes diagnosis or treatment. When the self-management education is provided during an office visit, the one payment for the office visit will be inclusive of the payment for the self-management education;

A certified diabetes nurse educator, certified nutritionist, or certified or registered dietician when referred by a physician or nurse practitioner. This education must be provided in a group setting. If it is determined that group education is not available in the covered person's area, benefits will be provided for the education when provided by a professional provider New York State Law requires the Plan to recognize; or

A professional provider described above during a visit to a patient's home. Benefits will only be provided for such education in the home when it is determined that it is medically necessary.

Dental Services

The Plan pays the allowable amount for medically necessary dental services rendered by a physician, dentist, or oral surgeon for the treatment of a congenital disease or anomaly; or of an injury to sound, natural teeth incurred as a result of an accident sustained while the individual is/was covered by the Plan. In the case of injury, care must commence within twelve (12) months following the date of the accident.

Dialysis

The Plan pays the allowable amount for institutional services and physician services for hemodialysis if the chronic kidney disease cannot be controlled by medicine.

Diagnostic X-Ray and Laboratory (Outpatient)

The Plan pays the allowable amount for medically necessary diagnostic x-rays and laboratory services done while the covered person is treated by an inpatient or outpatient facility as follows:

Diagnostic X-Rays: No additional co-payment is required for the reading and interpretation of diagnostic x-rays (if recognized as a separate service).

Diagnostic X-Ray and Laboratory (Outpatient) (Con't)

Diagnostic Laboratory Tests: No additional co-payment is required for the reading and interpretation of diagnostic laboratories (if recognized as a separate service).

Diagnostic Machine Tests: No additional co-payment is required for the reading and interpretation of diagnostic services of this type (if recognized as a separate service).

Radiology Services: The payment for radiology services includes the cost of radioactive matter.

Diagnostic X-Ray and Laboratory (Professional Provider)

The Plan pays the allowable amount for the following medically necessary diagnostic services. (The services must be ordered by a health professional to order the service or therapy):

- **D**iagnostic X-Rays: No additional co-payment is required for the reading and interpretation of diagnostic x-rays (if recognized as a separate service).
- **D**iagnostic Laboratory Tests: No additional co-payment is required for the reading and interpretation of Diagnostic laboratories (if recognized as a separate service).
- **D**iagnostic Machine Tests: No additional co-payment is required for the reading and interpretation of diagnostic services of this type (if recognized as a separate service).
- **R**adiology Services: The payment for radiology services includes the cost of radioactive matter.

Durable Medical Equipment

The Plan pays the allowable amount for the medically necessary rental or purchase of durable medical equipment. The Plan may pay for the repair and or maintenance of existing durable medical equipment in lieu of the re-purchase of replacement equipment. Durable medical equipment is used to serve a medical purpose and is designed to withstand repeated use. Durable medical equipment is generally not useful to a person in the absence of illness, injury or disease. The Plan will determine whether the equipment should be rented or purchased. A physician must order the equipment for the treatment or care of a condition before its rental or purchase. Although it is required that a physician order the equipment, such an order does not mean that the equipment will be automatically deemed to be medically necessary. Benefits will only be provided for equipment that is determined to be the least costly to adequately meet the needs of the condition. Benefits will not be provided for equipment that is primarily for the covered person's or their family's convenience.

Examples of such durable medical equipment are respirators, canes, crutches, walkers, and wheelchairs. Such equipment does not include, for example, air conditioners, dehumidifiers, physical fitness equipment, hearing aids,

Durable Medical Equipment (con't)

eyeglasses & contact lenses, or articles of clothing (including shoes), regardless of medical necessity. In addition, the Plan will not cover any changes to home, automobile, or personal property.

In addition, the plan will cover certain medical supplies when medically necessary. Verification of the medical necessity of medical supplies is encouraged prior to purchase.

Emergency Services

The Plan pays the medically necessary allowable amount for those covered services, supplies and facility related expenses that are provided by the hospital for emergency care given for an emergency condition. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

The person's health, or, in the case of a behavioral condition, the person's health or the health of others; could reasonably be in danger;

- **T**he person's bodily functions could be seriously impaired;
- **O**ne of the organs or other parts of the body could be seriously harmed; or
- **T**he person could be seriously disfigured.

Some examples of emergencies include heart attack or suspected heart attack, uncontrolled bleeding, loss of consciousness, severe shortness of breath, poisoning, suspected overdose of medication, severe burns, fractures, and high fever in infants. Emergency care treatments will be paid as an in-network benefit regardless of whether the emergency room facility is an in-network or out-of-network facility.

The unavailability of a private physician does not, by itself, constitute a medical emergency. Benefits will not be provided for outpatient follow-up care in the emergency or outpatient room of the hospital.

The Plan covers facility services and supplies used for the initial treatment and all follow-up care within 48 hours of traumatic bodily injuries resulting from an accident. However, if the accident services are classified as surgery (e.g., suturing, burn care, fracture care, etc.) payment will be made as a surgical benefit.

Gynecology (Routine)- see Preventive Services in this section for additional information

The Plan pays the allowable amount for routine gynecological visits, including coverage for cervical cytology screening for cervical cancer and its precursor states once a year, in addition to those services that are medically necessary as prescribed by a physician. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

Home Health Care Services

The Plan pays the allowable amount for certain medical services provided in the home by a home health care agency. Each visit by a home health care team is counted as one visit. Each period of up to four (4) hours of home health aide will be considered one visit. The maximum benefit for home health care is limited to 40 visits per calendar year.

For benefits to be paid, the following conditions must be satisfied:

Home Health Care Services (con't)

The patient must be under the care of a physician who submits a "home health care plan" prior to treatment in the patient's home, including certification that inpatient confinement in a hospital, convalescent nursing home, or skilled nursing facility would be required if home care were not provided;

The services and supplies furnished must be required during a confinement; and

It is determined that home health care is medically necessary.

Benefits will be provided for the following home health care services when provided and billed by a home health care agency:

Part time or intermittent home nursing care by or under the supervision of a registered professional nurse;
Part time or intermittent home health aide services which consist primarily of caring for the covered person;
Physical, occupational or respiratory therapy which is provided by the home health care agency;
Nutritional counseling; and
Medical supplies (including medicines) and laboratory services which are prescribed by the physician.

The above benefits will be covered when:

They are ordered by the physician; and
They are furnished in the patient's home.

Hospice Care

The Plan pays the allowable amount for the hospice care program if the covered person's primary attending doctor certifies that the covered person meets all of the following conditions:

The covered person experiences an illness for which the attending physician's prognosis for life expectancy is estimated to be less than six months or less;
Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate;
The attending physician refers the covered person to the hospice care program and is in agreement with the plan for care of the condition;
It is determined that hospice care is medically necessary; and
The covered person is formally admitted to the hospice program.

Covered Benefits Include Only the Following:

The confinement of a terminally ill patient as an inpatient in a hospice facility is covered; and
The hospice care furnished to the terminally ill patient, by the hospice provider, in the patient's home is covered.

Limitations and/or exclusions: The following charges are not covered:

Any charges incurred during a remission period are not covered. This applies if, during remission, the terminally ill person is discharged from the hospice care program.

Services provided by the covered person, the covered person's close family.

The maximum lifetime benefit for hospice care is 210 days.

Hospital Benefits

The Plan pays the allowable amount for inpatient hospital covered services if a covered person is:

A registered bed patient;
Required to stay in a hospital for acute care that is determined to be medically necessary; and
Not admitted to the hospital for mental, nervous, or emotional disorders, or chemical dependence including detoxification - except as defined under the inpatient psychiatric or the inpatient chemical dependence benefit.

When a covered person becomes confined in the hospital, the Plan covers the following services:

Room, board and general nursing services including ICU room and board charges, and all regular daily services, are paid up to the hospital's average semi-private room rate. If a physician certifies that a private room is a medical necessity for the purposes of isolation, charges will be covered at the hospital's average rate for a private room. If the facility has no such rooms, the Plan Administrator will use the rate most commonly charged by similar institutions in the same geographic area.
Hospital services and supplies, including patient meals, special diets, medicines, laboratory tests, use of operating rooms and special equipment, anesthetics and x-rays.
Mastectomy care consisting of an inpatient hospital stay following lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer. The medically appropriate length of stay will be determined by the attending physician, in consultation with the patient.
The charges are paid for a hospital's emergency room treatment of a sickness or injury.
The charges are paid for hospital services connected with outpatient surgery, including use of treatment rooms, x-rays, laboratory tests, surgical dressings and medicines.
The charges are paid for blood and blood plasma (not replaced on behalf of patient).

Important Note: The Plan does not cover room and board charges for weekend hospital admissions (Fridays or Saturdays) when treatment is not scheduled to begin until Monday. However, benefits will be payable if hospitalization and medically necessary treatments begin on these days .

Benefits are available for an unlimited number of inpatient hospital days of care, starting with the date of admission.

Benefits will not be provided for any hospital charges for use of the emergency room in connection with diagnostic services, radiology services, physical therapy, respiratory therapy, cardiac therapy, non-emergency care or follow-up care.

Infertility Treatment Services

The Plan will provide coverage for Medically Necessary services for the diagnosis and treatment on infertility subject to the following conditions:

Infertility Defined - For the purpose of this Section of the Plan Document, infertility has the meaning set forth in the regulations of the New York State Insurance Department and the guidelines of the American Society of Reproductive Medicine. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, or in the case of women over the age of 35, earlier evaluation and treatment may be justified after 6 months based on medical history and physical findings.

Coverage Provided for Individuals 21 to 44 Years of Age - The benefits provided by this section of the Plan Document are available only to covered persons who are between the ages of 21 and 44 as of the date the services are rendered.

Infertility Treatment Services (Cont.)

Coverage Provided Only for Appropriate Candidates - Coverage under this Section of the Plan Document will only be provided to "Appropriate Candidates" within the age group described previously. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

Covered Services - Subject to the other provisions of this Section of the Plan Document, the plan pays for benefits under this Section of the Plan Document for the following:

Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D" & "C"), that would correct malformation, disease or dysfunction resulting in infertility; and

Services in relation to diagnostic tests and procedures necessary:

To determine infertility; or

In connection with any surgical or medical procedure to diagnose or treat infertility, the diagnostic tests and procedures covered by this Section of the Plan Document are:

Hysterosalpingogram;
Hysteroscopy;
Endometrial biopsy;
Laparoscopy;
Sono-hysterogram;
Post-coital tests;
Testis biopsy;
Semen analysis;
Blood tests;
Ultrasound; and
Other Medically Necessary diagnostic tests and procedures, unless excluded by law.

Plan of Care Required - All services covered under this Section of the Plan Document must be prescribed by a physician as part of a Plan of Care. The Plan of Care must be in writing, and must be available for review by the Plan. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.

Services **must** be received from Eligible Providers - Services covered by this Section of the Plan Document must be received from "Eligible Providers" as determined by the Plan in accordance with applicable regulations of the New York State Insurance Department. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society of Reproductive Medicine.

Infertility Treatment Services (Cont.)

Excluded Services - The Plan will not pay for the following reproductive procedures or services:

In-Vitro Fertilization;
Gamete Intra-Fallopian Transfer (GIFT);
Zygote Intra-Fallopian Transfer (ZIFT);
Reversal of elective sterilizations, including vasectomies and tubal ligations;
Sex change procedures;
Cloning;
Sperm bank and donor fees associated with artificial insemination or other procedures;
Other procedures or categories of procedures excluded by statute.

Experimental Procedures Not Covered - This Section of the Plan Document does not cover services or procedures that the Plan determines to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. Covered persons may appeal the Plan's determination that a service or procedure is experimental to an external appeal agent as described in the Section of this Plan Document titled "Review and Appeal."

Deductibles, Co-payments and Coinsurance - The benefits of this Section of the Plan Document are subject to any applicable deductible, co-payment or coinsurance provisions under this section for similar services. For example, any deductible, co-payment or coinsurance for office visits, hospital admissions, surgery, laboratory/pathology and/or x-ray and imaging under the other provisions of the Plan Document will also apply to the office visits, hospital admissions, surgery, laboratory/pathology and/or x-ray and imaging under this Section of the Plan Document.

Inpatient Physician Services

The Plan pays the allowable amount for medically necessary visits by a physician when a covered person is registered as an inpatient in a hospital, skilled nursing facility or psychiatric hospital; provided the care is not in connection with surgery or maternity service. The benefits for provider visits will be based on the level of care given by the provider. Benefits will be provided for only one visit per day. When no benefit is provided for the inpatient stay, no benefit will be provided for a provider visit.

Payment of this benefit may be different under the following two instances:

Intensive Care Stay. If an illness or injury is so critical or serious that it requires constant personal attention by the professional provider while the patient is hospitalized, a higher amount may be paid.

Concurrent Care. If a patient is an inpatient in a hospital, and two or more professional providers treat the patient for separate and different conditions, benefits will be provided only when it is determined that the visits of each provider are medically necessary for the treatment of the separate conditions.

Unless the benefits are being provided for intensive care or concurrent care as defined above, the maximum benefit for the number of inpatient physician service visits is equivalent to the maximum benefit for the number of days under the hospitalization, skilled nursing facility and inpatient psychiatric benefit.

Mammography- See Preventive Services listed in this section for additional information

The Plan pays the allowable amount for mammography services once a year for covered females age 35 or older and for those which are medically necessary as ordered by a physician.

Maternity Care

The Plan pays the allowable amount for the medically necessary health professional services related to childbirth or miscarriage for covered persons. These services include prenatal, delivery and post-partum care.

Medical Supplies

The Plan pays the allowable amount for medically necessary medical supplies when a covered person is not an inpatient. Benefits for medical supplies include IV therapy, ostomy bags and supplies required for their use; catheters; and dressings, when it is determined that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, and burns. A physician must order the use of these supplies.

Newborn Care

The Plan pays the allowable amount for the hospital room and board, supplies, other professional services, including circumcision, furnished by the hospital, for a covered mother and her newborn, or a newborn who is covered at birth but whose mother is not covered, for at least 48 hours of care after a non-caesarean delivery, and at least 96 hours after a caesarean delivery. Benefits for the care or treatment of a newborn's illness or injury are only available if the newborn is a covered dependent under the Plan.

The services of the institutional provider must include, and the Plan covers, parental education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

If the mother chooses to be discharged from the hospital before the recommended time frames described above, benefits will be provided for one home health care visit rendered by a home health care agency. A home health maternity care visit must be requested within 48 hours of the time of delivery (96 hours in the case of a caesarean delivery). The visit must be rendered within 24 hours after discharge, or of the time of the request, whichever is later. The home health maternity care visit is not subject to co-payment or coinsurance if billed separately from the hospital's charge for maternity care services.

Oral Surgery

The Plan pays the allowable amount for the medically necessary oral surgery for the removal of bony impacted or soft tissue impacted teeth operative procedures involving the gum tissue and reduction fractures.

Organ/Tissue Transplants

The Plan pays the medically necessary allowable amount for the following:

- **O**rgan or tissue procurement from a cadaver which consists of removing, preserving, and transporting the donated part;
- **S**ervices and supplies furnished by a hospital;
- **D**rug therapy to prevent rejection of the transplanted organ or tissue; and
- **S**urgical storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant will be covered for each such procedure completed.

No benefits are payable for the purchase price of organs or tissue.

Some of the criteria used to make a benefit determination will include but may not be limited to the following:

Organs must have been from human donors, no other animal or artificial organs will be approved; and
Recipient must be in otherwise good general health and have a high probability of surviving the procedure.

Orthotic Devices

The Plan pays the allowable amount for the medically necessary purchase of orthotic devices. A physician must order the equipment for the treatment or care of a condition before its purchase. Although it is required that a physician order the device, such an order does not mean that the device will be automatically deemed to be medically necessary or essential. Benefits will only be provided for devices that are determined to be the least costly to adequately meet the needs of the condition.

Oxygen

The Plan pays the allowable amount for medically necessary oxygen, and for the rental equipment used in the administration of the oxygen, when prescribed by a physician.

Physical Therapy

The Plan pays the allowable amount for medically necessary physical therapy provided in a home, office, or hospital when rendered by a licensed physical therapist or physician. The therapy must be ordered by a physician. The physical therapy must be medically necessary for the diagnosis or treatment of the illness or injury.

Pre-Surgical Testing

The Plan pays the allowable amount for medically necessary pre-surgery testing ordered by a surgeon, if:

Proper diagnosis and treatment require the tests;
Surgery has been scheduled and an operating room has been reserved before the tests are given;
The tests are performed at an ambulatory surgical center or hospital; and
The tests are billed by, and payable to an ambulatory surgical center or hospital.

Prescription Drugs

The Plan pays for medically necessary prescription drugs.

The Plan pays the amounts that are in excess of the prescription drug co-payment.

The Plan pays for enteral formulas for which a physician or other provider licensed to prescribe has issued a written order. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific regimen for diseases or disorders that, if left untreated, will cause chronic disability, mental retardation, or death. Diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies that, if left untreated, will cause malnourishment, chronic disability, mental retardation or death. The Plan pays the amounts in excess of the generic prescription drug co-payment.

The Plan pays for Medically Necessary Infertility Drugs that the FDA has approved specifically for the diagnosis and treatment of infertility and that are prescribed or dispensed in connection with the services covered under the Infertility Treatment Services Section of this Plan Document.

The Plan also pays for low protein or modified protein solid food products when they are provided pursuant to a written order as described above for treatment of inherited diseases of amino acid and organic acid metabolism. The Plan pays the amounts in excess of the generic prescription drug co-payment.

Prescription Drugs (Con't)

The Plan provides coverage, for contraceptive drugs or devices approved by the FDA or generic prescription drug equivalents approved as substitutes by the FDA. The contraceptive drug or device must be prescribed for you by a provider that is legally authorized to prescribe pursuant to applicable law. Such contraceptive drugs and devices are not subject to copayments, annual deductibles or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

A prescription drug card will be issued to all covered persons. This card should be presented to the pharmacy at the time a prescription drug is purchased. If you do not use your prescription drug card, or go to a pharmacy outside of the network, then you must pay for your prescription and then file a claim with the prescription plan administrator. Any co-payments that are paid under the prescription drug program are not eligible to be considered for reimbursement under any other portion of the Plan.

**Orally administered cancer drugs –Cost sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost sharing amount or the Cost sharing amount, if any, that applies to intravenous or injectable chemotherapy agents.

The Plan requires pharmacies to dispense "Class A" generic drugs, which are widely accepted by the entire medical and pharmacy communities. Benefits will be provided as follows:

Tier I – drugs are typically generics and have the lowest copayment amount.
Tier II – drugs are brand name drugs that have unique, significant clinical advantages and offer overall greater value over the other products in the same drug class.
Tier III – drugs are all other brand drugs, including new brand drugs and drugs that have generic equivalents. Tier III drugs have the highest copayment amount.

Qualifying expenses as used in this prescription drug expense benefit provision are those expenses actually incurred, in excess of the co-payment, which are:

Necessary for the care and treatment of an illness;
Prescribed in writing by an authorized physician;
Reasonable and customary; and
Not listed in the Exclusion section, below.

However, there is an exception. If a prescription drug has been approved for use for one type of cancer, the Plan will also provide benefits for this prescription drug for use with other types of cancer; as long as it meets the requirements of the New York State Insurance Law.

Prescription Drugs (Cont.)

Mail Order Program

Part of the prescription drug program includes a voluntary mail order service. This service has been designed mainly for individuals using maintenance type medications for periods of 30 days or longer for treatment of chronic or long term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure.

How to use the program:

When a doctor prescribes a maintenance drug, have it written for up to a 90 day supply. By law the mail order administrator can only fill prescriptions with the quantity indicated by the doctor. (e.g. 1 a day = 90 pills, 2 a day = 180 pills) A covered person may want to ask their physician to write a prescription for a 30 day supply that can be taken to a retail pharmacy so that they will have a supply of the medication while the mail order request is being processed.

Complete a mail order form (mail order forms can be obtained by contacting the Plan Administration Office), and for new participants, complete the confidential patient profile. This form will need to be completed with the first order only. In the future, only additional information or changes to your medical condition need to be reported. Please notify the mail order administrator in writing.

Mail the completed form with the original prescription in the pre-addressed postage paid envelope.

Be sure the enrollee's social security number is written on the back of each prescription

Drugs will be delivered to the covered person's home postage paid by first class mail or Federal Express second day service. If there are any questions or problems concerning a prescription order, or if a prescription is not received within 14 days, please contact the mail order administrator. Allow a few extra days for first submissions.

Refills - For refills, contact the mail order administrator via there toll-free number and give them the enrollee's social security number and prescription number. The prescription label will indicate the number of times a prescription may be refilled.

Prescription Drug Exclusions:

The following exclusions apply to the prescription drug benefit:

Non-legend drugs, other than injectable insulin

Charges for the administration or injection of any drug

Therapeutic devices or appliances including needles, syringes, support garments, and other non-medical substances regardless of intended use, except those specifically listed as covered in this section.

Any prescription which a person is entitled to receive without charge from any Workers' Compensation, or similar law, or municipal, state or federal program other than Medicaid.

Prescription drugs purchased prior to the effective date of this Plan.

Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

Prescription Drug Exclusions: (Con't)

Drugs labeled "Caution-Limited by Federal Law to Investigation Use," or experimental drugs, even though a charge is made to the individual. However, the Plan will pay if required to provide coverage pursuant to the external appeal process.

Medication, which is to be taken by, or administered to, the covered person, in whole or part, while the covered person is a patient in a hospital, skilled nursing facility, rest home, sanitarium, extended care facility, convalescent hospital, or nursing home.

Immunization agents, biological sera, blood or blood plasma
More than a 90 day supply when dispensed in any one prescription order

Non-prescription vitamins, vitamin preparations (e.g. minerals, calcium, etc.), and nutritional supplements except for enteral formulas and modified solid food products, as described above

Cosmetic Drugs (e.g. Minoxidil (Rogaine), Renova, Retin-A)
Growth Hormones
Infertility Medications

Any prescription drugs specifically excluded herein may be covered by the Plan, subject to the prescription drug co-payment, if determined by the plan administrator to be medically necessary.

Preventive Care

The Plan covers the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost sharing (Copayments, Deductibles or Coinsurance) when performed by a participating provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items or services have an "A" or "B" rating from the United States Preventive services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP). However, cost sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the cost sharing amount that would otherwise apply to the office visit will still apply. You may contact Excellus at 1-800-499-1275 or visit the Excellus website at www.excellus.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

- **Well-Baby and Well-Child Care –** The Plan will cover well baby and well child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well child visits referenced above permits one well child visit per calendar year, we will not deny a well-child visit if 365 days have not passed since the previous well child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to copayments, deductibles or coinsurance when provided by a participating provider.

Preventive Care (Con't)

- **Adult Annual Physical Examinations –** The Plan covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

  Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the covered preventive service is available from Excellus at 1-800-499-1275or the Excellus website at www.excellus.com. You are eligible for a physical examination once every Plan year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

  This benefit is not subject to copayments, deductibles or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

- **Adult Immunizations –** The Plan covers adult immunizations as recommended by ACIP. This benefit is not subject to copayments, deductibles or coinsurance when provided in accordance with the recommendations of ACIP and when provided by a participating provider.

- **Well Woman Examinations –** The Plan will cover well woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the covered preventive services is available from Excellus at 1-800-499-1275or the Excellus website at www.excellus.com. This benefit is not subject to copayments, deductibles or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

- **Mammograms –** The Plan will cover mammograms for the screening of breast cancer as follows:

  - one baseline screening mammogram for women age 35 – 39
  - one baseline screening mammogram annually for women age 40 and over

  If a woman of any age has a history of breast cancer of her first degree relative has a history of breast cancer, the Plan will cover mammograms as recommended by her provider. However, in no event will more than one preventive screening, per Plan year, be covered.

  Mammograms for the screening of breast cancer are not subject to copayments, deductibles or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

  Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to copayments, deductibles and coinsurance.

- **Family Planning & Reproductive Health Services –** The Plan covers family planning services which consist of FDA approved contraceptive methods prescribed a provider, not otherwise covered under the prescription drug benefit in the "What the Medical Plan Covers" section of this policy, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to copayments, deductibles or coinsurance when provided in accordance with the comprehensive guidelines

Preventive Care (Con't)

supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

The Plan also covers vasectomies, subject to copayments, deductibles and coinsurance.

The Plan does not cover services related to the reversal of elective sterilizations.

- **Bone Mineral density Measurements or Testing –** The Plan will cover bone mineral density measurements or tests and prescription drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of prescription drugs is subject to the prescription drug benefit listed in the "What the Medical Plan Covers" section of this policy. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if you meet any of the following:

    - Previously diagnoses as having osteoporosis or having a family history of osteoporosis; or
    - With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
    - On a prescribed drug regimen posing a significant risk of osteoporosis; or
    - With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
    - With such age, gender, and/or other physiological characteristics which posa a significant risk for osteoporosis.

  The Plan will also cover bone mineral density measurements or tests, and prescription drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

  This benefit is not subject to copayments, deductibles or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a participating provider.

- **Screening for Prostate Cancer –** The Plan will cover an annual standard diagnostic examination incuding, 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. The Plan will also cover 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.

  This benefit is not subject to copayments, deductibles or coinsurance when provided by a participating provider.

Professional Provider Office Visit

The Plan pays the allowable amount for the diagnosis or treatment of illness or injury (except for the diagnosis and treatment of a mental, nervous or emotional disorder or chemical dependence) in the provider's office or in the covered person's home.

Prosthetic Devices

The Plan pays the allowable amount for the medically necessary, purchase of prosthetic devices. A physician must order the equipment for the treatment or care of a condition before its purchase. Although it is required that a physician order the device, such an order does not mean that the device will be automatically deemed to be medically necessary. Benefits will only be provided for devices that are determined to be the least costly to adequately meet the needs of the condition.

Examples of such prosthetic devices are braces and artificial arms, legs, and eyes used to replace functioning natural parts of the body. Such devices do not include, for example, hearing aids, eyeglasses & contact lenses, cosmetic devices, or wigs. Dentures or other devices used in connection with the teeth are also not covered unless required due to injury to sound natural teeth.

Psychiatric Treatment - Inpatient

The Plan pays the allowable amount for the medically necessary diagnosis and treatment of mental, nervous, or emotional disorders rendered in a hospital or psychiatric hospital, as defined by §1.03 (10) of the Mental Hygiene Law. Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.

To be eligible for inpatient psychiatric care services, a covered person must be a registered inpatient and the inpatient stay must be determined to be medically necessary.

Psychiatric Treatment - Outpatient

The Plan pays the allowable amount for medically necessary professional provider services for the outpatient diagnosis and treatment of a mental, nervous, or emotional disorder.
Outpatient mental illness treatment expenses include the following services when rendered by certain provider or in certain approved facilities. The covered outpatient providers are: licensed physicians psychiatrists, psychologists, psychotherapists, clinical social workers (CSW), professional corporations, and university faculty practice corporations. The covered outpatient facilities are: facilities issued an operating certificate by the commissioner of mental health, and facilities operated by the office of mental health.

Oral and written diagnostic tests;
Consultation visits;
Diagnostic visits;
Physician's personal treatment visits; or
Group therapy

In addition, coverage includes services furnished by a comprehensive health service organization, licensed or accredited hospital, community mental health center, or other mental health clinic, and is licensed or approved to provide such services by the state where the services are rendered.

Psychiatric Treatment - Biologically Based Mental Illness; Children with Serious Emotional Disturbances

The following definitions shall apply to this Section of the Plan Document:

Biologically Based Mental Illness - A mental, nervous or emotional condition that is caused bya biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically based mental illnesses are defined as the following;

Psychiatric Treatment - Biologically Based Mental Illness (con't)

Schizophrenia/psychotic disorders;
Major depression;
Bipolar disorder;
Delusional disorders;
Panic disorder;
Obsessive compulsive disorders;
Bullimia; and
Anorexia.

Children with Serious Emotional Disturbances - Persons under the age of 18 years who have diagnosis of attention deficit disorders, disruptive behavior disorders or pervasive development disorders, **and** where one or more of the following are present:

Serious suicidal symptoms or other life-threatening self-destructive behaviors;
Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
Behavior caused by emotional disturbances that placed the child at significant risk of removal from the household.

The benefits in the Plan Document Sections titled Psychiatric Treatment Inpatient and Psychiatric Treatment Outpatient above include benefits for Biologically Based Mental Illness and for Children with Serious Emotional Disturbances; however. Benefits for Biologically Based Mental Illness and for Children with Serious Emotional Disturbances are not subject to any day limit for inpatient days or outpatient visit limits that may apply to mental health care and will be comparable to the benefits provided for medical conditions under this Plan Document.

Benefits under this Section of the Plan Document will be subject to the same cost sharing that applies to similar medical benefits under this Plan Document.

Radiation Therapy

The Plan pays the allowable amount for the medically necessary treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes. The benefit for radiation therapy includes the cost of any radioactive matter.

Reconstructive or Corrective Surgery

The Plan pays the allowable amount for medically necessary reconstructive or corrective surgery only if such surgery is:

To correct an abnormal congenital condition in a child,
To repair or alleviate damage which occurred as the result of an accident,

Reconstructive or Corrective Surgery (Con't)

To repair an injury which occurs while the person is covered under this Plan, or

To comply with the Women's Health and Cancer Rights Act of 1998. Services include reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas in a manner determined by the attending physician and the patient to be appropriate.

Respiratory Therapy

The Plan pays the allowable amount for medically necessary respiratory therapy.

Second Medical Opinion (Cancer-Related)

The Plan pays for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by a physician as having some form of cancer. A negative diagnosis of cancer occurs when a physician performs a cancer screening exam on the covered person and finds that the covered person does not have cancer, based on the exam results. The plan will also pay for a second medical opinion concerning any recommendation of a course of treatment for cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to a specialist associated with a specialty care center for the treatment of cancer. The Plan will pay in-network benefits under circumstances where your physician provides a written referral to an out-of-network physician for the second medical opinion.

Second Surgical Opinion

A second surgical opinion is recommended for certain procedures including, but not limited to, the following:

Breast Surgery
Hysterectomy
Carpal Tunnel Release
Spinal Surgery
Exploratory Laparotomy
Gastric Bypass and Stapling
Hip Replacement Surgery
Cardiovascular Bypass Surgery
Nasal Surgery
Dilation and Curettage
Tonsillectomy and/or Adenoidectomy
Cardiac Catheterization
Knee Surgery
Cataract Removal
Surgery to correct Varicose Veins

A second surgical opinion is not mandatory; however, some elective surgery is unnecessary, and physicians may disagree on the need for such surgery. An opinion from a second physician may save the covered person time, discomfort, and costs that accompany surgery.

The Plan pays the allowable amount for additional surgical opinion(s), including charges for diagnostic x-ray and laboratory testing; however, no benefits will be allowed for duplicate testing.

Skilled Nursing Facility

The Plan pays the allowable amount for services provided by a skilled nursing facility while a covered person is recovering from an illness or injury for the same or related causes. Benefits include room and board charges and other necessary services and supplies (except physician's fees and personal items) furnished while the patient is under continuous care of his/her physician, and requires 24-hour nursing care. Benefits will not exceed the standard semi-private rate in the hospital from which the patient was transferred. This benefit is limited to 365 days per calendar year maximum. The admission must be within 30 days of a prior hospital stay.

To be eligible for inpatient skilled nursing facility services, a covered person must meet all of the following conditions:

A registered bed patient in a skilled nursing facility; and

The stay in the skilled nursing facility is for skilled care or treatment that is medically necessary; and
The patient would otherwise require skilled care as a hospital inpatient if they were not in the skilled nursing facility.

Skilled Nursing Facility (con't)

Inpatient skilled nursing facility covered services include the following:

Nursing care given or supervised by a registered nurse;

Bed and board in a semi-private room;

Physical or respiratory therapy given by the skilled nursing facility, or by a health provider under an agreement with the skilled nursing facility;

Drugs, supplies, and equipment used in and furnished by the skilled nursing facility; and

Other services generally provided by the skilled nursing facility that would be covered if the person was an inpatient in a hospital.

Sterilization

The Plan pays the allowable amount for sterilization procedures provided they are medically necessary. The Plan also pays the allowable amount for an initial elective sterilization. The Plan excludes coverage for the reversal of any sterilization procedures.

Surgical Services Benefit

The Plan pays the allowable amount for medically necessary surgical services and supplies. Surgical services include incisions or punctures of the skin or other tissue, reduction of fractures and dislocation of bones and endoscopies. Covered services include surgeon's fees for the performance of surgery and related pre- and post-operative care; however, if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field:

The allowable amount will be paid for the major procedure; and

The allowable amount for a secondary procedure will be reduced by 50%.

Secondary procedures that are determined to be incidental will not be covered.

Urgent Care Center

The Plan pays the allowable amount for facility services and supplies for the diagnosis or treatment of illness or injury in an urgent care center.

Well Child Visits – See benefits listed under "Preventive Care" in this section.

X-Ray and Radium Therapy

The Plan pays the allowable amount for medically necessary x-ray, radium treatments, treatments with other radioactive substances, and chemotherapy. The benefit includes the cost of any radioactive matter.

WHAT THE MEDICAL PLAN DOES NOT COVER

General Exclusions

1. Any services or care that is eligible for coverage by mandatory no-fault automobile insurance until the covered person has used up all the benefits under the mandatory no-fault policy. If a claim for no-fault benefits is denied, the covered person must file for an arbitration hearing if the plan administrator requests such. This exclusion applies even if the covered person does not make a proper or timely claim for benefits available under the no-fault policy. Should the no-fault policy have a deductible, benefit payment will be made for covered services up to the amount of the deductible.

2. No benefit payment will be made for any service or care for which benefits are payable under Medicare; or for which benefits are paid under any other federal, state or local government program; except when required by state or federal law. When a covered person is eligible for a government program other than Medicare that is subject to this exclusion, benefits will be reduced by the amount the government program paid for the services. When a covered person is eligible for Medicare, benefits will be reduced by the amount Medicare would have paid for the services. This reduction is made even if:

   The covered person fails to enroll in Medicare; or
   The covered person does not pay the charges for Medicare.

   However, this exclusion will not apply to the covered person, if one of the following applies:

   A. Eligibility for Medicare by Reason of Age. The covered person is entitled to benefits under Medicare by reason of age, and the following conditions are met:

      1. The employee is in "current employment status" (working actively and not retired) with a participating municipality; and

      2. The employee's participating municipality is required by law to have this Plan pay its benefits before Medicare.

   B. Eligibility for Medicare by Reason of Disability Other than End-Stage Renal Disease. The covered person is entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

      1. The employee is in "current employment status" (working actively and not retired) with a participating municipality; and

      2. This Plan is a large group health plan, as defined by law, and the participating municipality is, therefore, required by law to have this Plan pay its benefits before Medicare pays.

   C. Eligibility for Medicare by Reason of End-Stage Renal Disease. The covered person is entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. Benefits will not be reduced, and this Plan will pay before Medicare pays, during the waiting period. This Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before this Plan pays its benefits.

3. Any expense incurred while on full-time active duty in the armed forces of any country, combination of countries, or international authority.

General Exclusions (Cont.)

4. Any expense incurred in connection with any accidental bodily injury or illness arising out of, or in the course of any employment (past or present), and which is received by the covered person under any Workers' Compensation or Occupational Disease Act or law.

5. Services received in a public health service hospital, or any facility operated by the U.S. government or any of its agencies are not covered, unless the benefit payment will be made for only service or care for non-service related conditions.

6. Inpatient hospital care received by retirees or dependents described in SS.1074(b), 1076(a), or 1076(b) of Title 10, United States Code is not covered. These codes state that a retiree and/or a dependent of a retiree who was in a uniformed service may be given medical and dental care in any facility of any uniformed service, subject to availability of space and capabilities of the staff. Therefore, if care is received at a facility of any uniformed service, this Plan will not duplicate benefits.

7. Dental Services: The Plan does not cover any dental services unless specified in the Benefit Summary Section and the What the Medical Plan Covers Section.

8. Optical Services: The Plan does not cover charges for exams to determine the need for (or change of) eyeglasses or lenses of any type except for the medically necessary initial replacements for loss of the natural lens(es). The Plan does not cover charges eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring), orthoptics, visual therapy, or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity.

9. Any expense for services rendered by the covered person or the covered person's immediate family members.

10. Any service or care in connection with chronic problems of the feet except as specified in the Benefit Summary and the What The Medical Plan Covers Sections above.

11. No payment will be made by the Plan for any expenses for services in connection with elective cosmetic surgery that is primarily intended to improve the covered person's appearance. Such services include, but are not limited to, breast reduction or enlargement, rhinoplasty, and hair transplants. The Plan will, however, pay for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Plan will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under the Plan that has resulted in a functional defect. The Plan will also provide coverage for services in connection with reconstructive surgery following a mastectomy as specified in the Benefit Summary and the What The Medical Plan Covers Sections. Please note that all cosmetic surgery is subject to a determination of medical necessity and that any adverse determinations of medical necessity could be appealed following the appeals procedure.

12. Services or care that is furnished without charge, or that would have been furnished without charge if the recipient was not covered under the provisions of this Plan.

General Exclusions (Cont.)

13. Proper adjustment of, or purchase of a hearing aid.

14. Services of a private duty registered nurse or licensed practical nurse furnished in a hospital, even if ordered by a health professional, except if the attending physician certifies in writing that a certified registered nurse was not available provided in any case that such nurse is one who does not ordinarily reside in the home of the covered person and is not a member of the covered person's family.

WHAT THE MEDICAL PLAN DOES NOT COVER

Non – Covered Benefits

1. Any expense for services not directly related to, or medically necessary for, the diagnosis or treatment of an illness or injury, unless specified in the Benefit Summary Section and the What The Medical Plan Covers Section.

2. Any services if the covered person was an inpatient in any institutional provider, or receiving home care or hospice benefits, on the day coverage begins under the Plan. This exclusion only applies if the covered person is eligible for benefits from another insurance carrier for the dates services were rendered. However, after the discharge from the facility or program, benefit payments for future covered services will be provided.

3. Any expense which exceeds the AE amount.

4. Any expense for care, services, and supplies not prescribed by a licensed health provider and/or treatment not rendered by a licensed health provider.

5. Any routine or elective expenses not mandated by state or federal law except as deemed medically necessary by the plan administrator.

6. Custodial care.

7. Any service or care for outpatient occupational or speech therapy, except when provided as part of the home health care services benefit of the Plan.

8. Expenses applied toward satisfaction of the deductible.

9. Blood or blood plasma that is replaced by or for the patient.

10. Expenses for a standby physician.

11. Any service or care related to conception by artificial means, including, but not limited to, fertility drugs, in vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cryopreservation of sperm or embryos, intracytoplasmic sperm injection, surrogate parenting (except that benefits will be provided for covered services rendered to a surrogate parenting (except that benefits will be provided for covered services rendered to a surrogate parent who is covered under this Plan), or other techniques or methods of assisted reproductive technology that may be developed, the intended outcome of which is similar to these procedures, unless otherwise required by law. This exclusion applies but is not limited to the following services: birth control counseling, genetic counseling, and diagnostic testing for the sole purpose of inducing pregnancy.

12. Any expense for career or pastoral counseling.

13. Services or supplies of an educational, experimental or investigatory nature.

    "Educational" means that the primary purpose of a service or supply is to provide the covered person with any of the following training in the activities of daily living: instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Non – Covered Benefits (con't)

"Experimental" and "investigational" mean that the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the physician's profession in the United States as safe and effective for diagnosis or treatment.

This includes, but is not limited to:

All phases of clinical trials;
All treatment protocols based upon or similar to those used in clinical trials;
Drugs approved by the Federal Food and Drug Administration under its treatment investigatory new drug regulation; or
Federally approved drugs used for unrecognized treatment indications.

In determining those expenses which meet the definition as stated above, the Plan will utilize the Health Care Finance Administration (HCFA) guidelines and the Food and Drug Administration (FDA) guidelines as the standard by which services will be reviewed, where available.

Although the Plan contains an exclusion for experimental and investigational services, the Plan will pay for such services if directed pursuant to external appeal.

This exclusion shall not limit in any way benefits available for prescription drugs otherwise covered under the Plan that have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of the New York Insurance Law.

14. Charges for unnecessary services or supplies. A charge for services or supplies, including tests and check-up exams to the extent that they are not needed for the diagnosis of a sickness or injury, or the medical care of a diagnosed sickness or injury, unless specified in the Benefit Summary Section under Preventive Care.

15. Charges for the reversal of any sterilization procedure.

16. Expenses for sex transformation including but not limited to hormones and any psychiatric treatment related to the transformation, unless medically necessary.

17. Charges for orthoptic therapy (vision exercises).

18. Services for weight reduction programs.

19. Any services related to terminal illness that have been or should be included in the payment to a hospice program. Bereavement counseling services, except as provided under the Hospice Benefit provisions.

20. Hypnosis.

21. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

22. LaMaze (type) classes - child bearing classes.

Non – Covered Benefits (con't)

23. Mail and/or shipping and handling expenses.

24. Travel expenses of a health provider or a covered person.

25. Sale(s) tax.

26. Adoption expenses.

27. Any service or care when it is determined that the service or care is not expected to improve the condition of the recipient. This exclusion is independent of the hospice care benefit.

28. Any pharmacy services, clinical laboratory, x-ray or imaging services that were provided pursuant to a referral prohibited by New York State Public Health Law.

29. Any prescription medicine or insulin not covered under the prescription drug benefit, except:

    Where required by law; or
    Billed by an institutional provider while rendering services covered under the provisions of the Plan.

30. No benefit payment will be made for the elective termination of a pregnancy, including abortion, and related expenses incurred therefore.

DEFINITIONS

The following words and phrases are NOT intended to imply that coverage for them is provided under the Plan.

Ambulatory Surgical Center: The coverage of such a facility is mandated by law, and it has been licensed by the regulatory authority having responsibility for such licensing under the laws in the jurisdiction in which the facility is located; or, the coverage of such a facility is not mandated by law, but it meets all of the following requirements:

It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located, and the facility is primarily for the purpose of performing surgical procedures.

It is operated under the supervision of a licensed Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision, and permits a surgical procedure to be performed only by a duly qualified physician who is privileged to perform such a procedure in at least one Hospital (as defined) in the area at the time the procedure is performed.

It requires, in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure.

It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

It provides at least one operating room, and at least one post-anesthesia recovery room. It must be equipped to perform diagnostic x-ray and laboratory examinations, and has available to handle foreseeable emergencies with trained personnel and necessary equipment including, but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or who require post-operative confinement.

It maintains an adequate medical record for each patient; such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history, laboratory test and/or x-rays, operative report, and a discharge summary.

It provides a physician trained in cardiopulmonary resuscitation.

Autism Spectrum Disorder: Any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified.

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

Bereavement Counseling: Counseling provided to the immediate family by the hospice program due to the loss of a terminally ill loved one who was in the hospice program.

DEFINITIONS

Birthing Center: A specialized free-standing facility that meets all of the following criteria:

Meets licensing standards, and is set up, equipped, and run to provide prenatal care, delivery, and immediate post-partum care.

Makes charges.

Is directed by at least one physician who is a specialist in obstetrics and gynecology.

Has a physician or certified nurse midwife present at all births and during the immediate post-partum period.

Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.

Provides, during labor, delivery, and the immediate post-partum period, full-time skilled nursing services directed by a registered graduate nurse (R.N.) or certified nurse midwife.

Provides, or arranges with a facility in the area for diagnostic x-ray and laboratory services for the mother and child.

Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.

Is equipped and has trained staff to handle medical emergencies, and it provides immediate support measures to sustain life if complications arise during labor, and/or if the child is born with an abnormality which impairs function or threatens life.

Accepts only patients with low risk pregnancies.

Has a written agreement with a hospital in the area for emergency transfer of a patient or child. Written procedures for such a transfer must be displayed, and the staff must be aware of them.

Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.

Keeps a medical record on each patient and child.

Brand Name (as used in drugs and medicines): The term "Brand Name Drugs and Medicines" means the trade name under which a covered drug or medicine is advertised and sold.

Calendar Year: The period beginning 12:00 A.M. January 1, through 11:59 P.M. December 31, inclusive.

Cardiac Rehabilitation: The medically necessary services rendered to maximize or improve cardiac function and endurance when performed after such conditions as heart attacks and heart surgery.

Certified Nurse Midwife: A licensed, registered nurse who has been certified by the American College of Nurse Midwives as a Nurse Midwife.

DEFINITIONS

Chemical Dependence: The prolonged use of drugs, including alcohol, that cause physical and mental impairment; a drug (including alcohol)-induced disorder that produces a state of psychological and/or physical dependence.

Chemical Dependence Treatment Facility: The facility must meet at least one of the following criteria:

> **I**t is a public facility that provides services, especially for detoxification or rehabilitation, and it is licensed to provide those services in the state in which the facility is located.
>
> **I**t is a comprehensive health service organization, or community mental health clinic, that furnishes mental health services with the approval of the appropriate governmental authority; or it is any public facility, or portion thereof, that provides services especially for rehabilitation. It must be licensed for these purposes.
>
> **I**t is a licensed or accredited hospital, or a facility that is affiliated with a hospital under a contractual agreement.

A Chemical Dependence Treatment Facility must also:

> **H**ave an established patient referral system; and
>
> **B**e accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Concurrent Review: A voluntary evaluation which the covered person receives through the Plan during a hospital confinement that certifies the treatment and specifies a length of stay as medically necessary.

Confined/Confinement: Being an inpatient in a hospital, skilled nursing facility or a chemical dependence treatment facility.

Coinsurance: The percentage of benefit payable by the Plan, and the percentage of benefit which is payable by the covered person for services rendered, until the out-of-pocket limit has been reached.

Co-payment: A flat, fixed-dollar amount which shall be payable by a member of this Plan to a provider of services, regardless of the charge for such services.

Convalescent Hospital: An institution or part thereof constructed and operated pursuant to law which meets all of the following criteria:

> **O**verseen by a physician and operates under the supervision of a physician or a registered graduate nurse. Full-time supervision means a physician or registered graduate nurse is regularly on the premises at least 40 hours per week.
>
> **M**aintains a daily medical record for each patient
>
> **H**as a written agreement or arrangement with a physician to provide emergency care for its patients
>
> **Q**ualifies as an "Extended Care Facility" under the health insurance provided by Title XVIII of the Social Security Act, as amended

Convalescent Hospital: (Cont.)

(**F**or those which are not an integral part of a hospital) has a written agreement with one or more hospitals providing for the transfer of patients and medical information between the hospital and convalescent hospital.

In no event, however, will a convalescent hospital be deemed to include an institution which is, other than incidentally, a place of rest, a place for the aged, the chemically dependent, the blind or deaf, the mentally ill or retarded, or a place of custodial care.

Cosmetic Surgery: Surgical procedures, usually plastic surgery, directed toward preserving or correcting physical appearance.

Covered Dependent: Any eligible dependent whose coverage became effective and has not terminated.

Covered Person: Any eligible employee/retiree or eligible dependent whose coverage became effective and has not terminated.

Covered Services: These are the expenses incurred by a covered person for any medically necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this document.

Custodial Care: Care that provides help in transferring, eating, dressing, bathing, toileting, and other such related activities.

Deductible: This is the amount of out-of-network covered expenses the covered person must incur during the accumulation period before the Plan pays benefits. The Benefit Summary Section shows the deductible amount.

Dentist: Doctor of Dental Surgery, or Doctor of Dental Medicine.

Durable Medical Equipment: Equipment prescribed by the attending physician which is:

Medically necessary;
Not primarily and customarily used for non-medical purposes;
Designed for prolonged use; and
Designed for a specific therapeutic purpose in the treatment of an illness or injury

Emergency Condition: A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

DEFINITIONS

Emergency Services: A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. Emergency Services are not subject to prior authorization.

Employer: A participating municipality in Tompkins County.

Experimental & Investigational: "Experimental" and "Investigational" mean that the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the physicians' profession in the United States as safe and effective for diagnosis or treatment.

This includes, but is not limited to:

All phases of clinical trials;
All treatment protocols based upon or similar to those used in clinical trials;
Drugs approved by the Federal Food and Drug Administration under its Treatment Investigatory New Drug regulation; or
Federally approved drugs used for unrecognized treatment indications.

In determining those expenses which meet the definition as stated above, the Plan will utilize the Health Care Finance Administration (HCFA) guidelines and the Food and Drug Administration (FDA) guidelines as the standard by which services will be reviewed, where available. However, this shall not limit in any way benefits available for prescription drugs otherwise covered under the Plan that have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of the New York Insurance Law.

Extended Care Facility: Any one of the following:

A facility owned and operated by a hospital, or under written contract with a hospital.
A distinct part of a hospital;
A facility, or distinct part of a facility, that meets the requirements for approved operation under Medicare.

All the following must be true. The facility must:

Be operated according to the laws of the state or locality in which it is located. This includes the necessary licensing.
Be primarily engaged in providing care for persons recovering from sickness or injury.
Be under the supervision of a physician or staff of physicians on call at all times.

It must provide all the following:

Room and board.
Skilled 24 hours per day inpatient nursing services; a full-time R.N. or other nursing staff under the supervision of a physician or R.N. on duty at least eight (8) hours per day.
Adequate daily medical records for each patient.
Necessary and customary special services.

DEFINITIONS

An Extended Care Facility is not an institution that is mainly a clinic, rest home, home for the aged, or place for custodial care.

Full-Time Student: A dependent child who is enrolled in, regularly attends, and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of a registered nurse, or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain full-time student status.

Generic Substitutes for Drugs and Medicines: The term "Generic Substitute for Drugs and Medicines" means the chemical name of the covered drug or medicine.

Health Professionals: Physicians, dentists, podiatrists, clinical psychologists, and other professionals who must be under the direct supervision of a physician, who are engaged in the delivery of health services and are licensed, certified, or otherwise practice under authority of state law.

Home Health Care Agency: A nonprofit public home health care service or agency possessing a valid certificate or approval issued in accordance with Title XVIII of the Social Security Act, or licensed and approved by the State.

Home Health Care Plan: A program for care and treatment of a covered person, established and approved in writing by such covered person's attending physician's certification that the proper treatment of the injury or sickness would require confinement as a resident inpatient in a hospital, or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, in the absence of services and supplies provided as part of the home health care plan.

Hospice Facility: A facility which provides short periods of stay for a terminally-ill covered person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program. If such a facility is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a hospice.

Hospice Care Program: A formal program directed by a physician to help care for the terminally ill covered person. This may be through either a centrally administered, medically directed and nurse-coordinated program which provides a coherent system primarily of home care, uses a hospice team; and is available 24 hours a day, seven (7) days a week; or, confinement in a hospice.

The program must meet standards set by the National Hospice organization and approved by the plan administrator. If such a program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a hospice care program.

Hospice Services: Services and supplies furnished to a terminally ill covered person by a hospice and/or hospice team.

Hospice Team: A team of professionals and volunteer workers who provide care to reduce or abate pain or other symptoms of mental or physical distress, and meet the special needs arising out of the stresses of the terminal illness, dying, and bereavement. The team includes at least a physician, and a registered graduate nurse and could include at least one of the following:

A social worker;	**A** clergyman/counselor;	**A** physiotherapist; or an
occupational therapist	***A** clinical psychologist*	**V**olunteers;

DEFINITIONS

Hospital: A hospital shall be an institution which meets all of the following requirements:

It must be primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment, and care of injured or sick covered persons;

It must have organized departments of medicine and surgery;

It must have a requirement that every patient must be under the care of a physician or dentist;

It must provide 24 hour nursing service by, or under the supervision of, a registered graduate nurse (R.N.);

It is duly licensed by the state agency responsible for licensing such hospitals, if licensing is required;

It is not, other than incidentally, a nursing home or an institution, or part of one, which is primarily a place of rest, a place primarily for the treatment of tuberculosis, mental or emotional disorders, a place for the aged, or the chemically dependent, neither is it a place for custodial care, nor is it operated primarily as a school; and

It can also be an intermediate care facility which in itself is an institution that provides care and treatment of mental, psychoneurotic or personality disorders, or chemical dependence, through one or more specialized programs.

A hospital must also:

Be staffed by registered graduate nurses and other mental health professionals;

Provide for the clinical supervision of such specialized programs by physicians who are licensed in the state in which the facility is located; and

Ensure that each specialized program provided by it must:

Furnish a written individual treatment plan which states specific goals and objectives.

Maintain at a minimum on-going weekly progress notes which demonstrate periodic review, and direct patient care by the attending physician.

A Hospital must also:

Be accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or

Be licensed, accredited, or approved by the appropriate agency in the state in which it is located, to provide the type of specialized program described above.

In no event will the term “hospital” include a nursing home or an institution or part of one which:

Is primarily a facility for convalescence, nursing, rest, or the aged;

Furnishes primarily domiciliary or custodial care, including training in daily living routines; or

Hospital: (Cont.)

Is operated primarily as a school.

The following are not considered hospitals: ambulatory surgical centers; freestanding diagnostic and treatment centers; nursing homes; skilled nursing facilities (SNF's); school, college, or camp infirmaries; rehabilitation facilities; and places mainly for the care and treatment of the aged, chemical dependence, mental disorders, and tuberculosis.

Partial Hospitalization is treatment in a hospital or other licensed facility for less than 24 hours but more than four hours in any one day.

Illness: Sickness or disease which causes loss covered by the Plan. Losses incurred by a covered person because of pregnancy, childbirth, and related medical conditions are covered under the Plan to the same extent as any illness.

Injury: Bodily harm which results from an accident, and which results in loss covered by the Plan.

Inpatient: A covered person who is admitted to a hospital, skilled nursing facility or chemical dependence treatment facility and who incurs room and board charges.

L.P.N.: A licensed, practical nurse, who is recognized by the state in which care is given as qualified to perform limited nursing functions.

Maternity: Pregnancy, including resulting childbirth, spontaneous abortion, and miscarriage shall be treated the same as a disease or illness.

Medically Necessary/Medical Necessity: A medically necessary service or supply is one that is:

Provided for the treatment or diagnosis of an illness or injury, including premature birth, congenital and other birth defects;

Necessary to meet a patient's basic health needs;

Appropriate for the symptoms, consistent with the diagnosis, and in accordance with generally accepted medical practice and professionally accepted standards;

Not recommended because it is more convenient for the patient, the physician, or other provider; and

The most appropriate method of providing safe and adequate care.

Confinement in a hospital or other facility is considered medically necessary when the covered person needs to be confined because of the nature of the services that the covered person requires, or when treatment for the covered person's condition would be considered unsafe or inadequate if performed on an outpatient basis.

Treatment that is educational or done primarily for research will not be considered medically necessary.

A benefit payment will not be made if the plan administrator determines that the service, care, or supply was not medically necessary. However, the Plan will pay benefits if directed to do so pursuant to external appeal.

Medically Necessary/Medical Necessity: (Cont.)

The fact that any particular physician or health care professional may prescribe, order, recommend, or approve service, supply or technology does not, in itself, make the services medically necessary.

The definition of medical necessity relates only to coverage and may differ from the way in which a provider engaged in the practice of medicine may define medical necessity.

Medicare: The insurance program established by Title XVIII, United States Social Security Act, as first enacted by the Social Security Amendment of 1965, or as later amended.

Mental Illness: A mental, nervous or emotional condition that, in the Plan's judgment, has treatable behavioral manifestations and that the Plan determines:

Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and

Substantially or materially impairs your ability to function in one or more major life activities; and

Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders."

Military Service: Service in any Army, Navy, Air Force, Marines, Coast Guard, or other branch of the military.

Network Provider: All physicians, health professionals, hospitals, or other organizations having an agreement with the Plan.

Orthotics: The use of orthopedic devises used to correct or relieve a condition which is caused by an illness or injury.

Outpatient: A covered person who receives a diagnosis or treatment at a facility, but does not incur room and board charges.

Outpatient Mental Health Treatment Facility: A comprehensive health service organization, a licensed or accredited hospital, or community mental health center, or other mental health clinic which furnishes mental health services with the approval of the appropriate governmental authority, any public facility or portion thereof which provides services especially for the diagnosis, evaluation, service, or treatment of mental illness or emotional disorder. Covered outpatient facilities are issued an operating certificate by the commissioner of mental health and include facilities operated by the office of mental health.

Physician: A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), a Dentist (D.M.D. or D.D.S.), a Psychologist (Ed. Or Ph. D.), a Podiatrist (D.P.M.), a Chiropractor (D.C.), or an Optometrist (O.D.), licensed or certified to practice in the state in which the treatment is received and acting within the scope of his/her license/certification. State law may specify that benefits be paid for the professional services of a practitioner other than a medical physician. In that case, the term physician also includes persons recognized by the state in which the treatment is received as being qualified to treat the sickness or injury for which claim is made.

Physical Therapy: Rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet, and massage are used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living.

Plan: The Greater Tompkins County Municipal Health Insurance Consortium Indemnity Plan.

DEFINITIONS

Plan Administrator: The person or organization providing consulting services to the employer in connection with the operation of this Plan and performing such other functions, including processing and payment of claims as may be delegated to it. The plan administrator is:

Excellus BlueCross BlueShield of the Central New York Region
333 Butternut Drive
Syracuse, NY 13214-1803
(877) 757-3850

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of this plan, January 1, 2010.

Podiatry: The diagnosis, treatment, and prevention of conditions of human feet.

Pre-admission Certification: An evaluation which the covered person receives through the Plan prior to a hospital admission. It certifies the covered person's proposed hospital admission and length of stay as medically necessary; subject to a contrary determination upon retrospective review.

Prescription Drugs: Drugs and medicines which require a prescription by a physician to dispense. These drugs must be approved by the U.S. Food and Drug Administration for general use in treating the sickness or injury for which they are prescribed. However, this shall not limit in any way benefits available for prescription drugs otherwise covered under the Plan that have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of the New York Insurance Law Section 4303(q).

Primary Attending Physician: This is the physician who is treating the terminally-ill person, and recommends admittance to a hospice care program.

Preventive Care: The branch of medicine concerned with the prevention of physical illness and disease.

Psychiatric Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders, and which is operated pursuant to law, and meets all of the following requirements:

Must be licensed to give medical treatment;

Is operated under the supervision of a physician;

Must provide on the premises all the necessary facilities for medical treatment; and

Is not, other than incidentally, a place of rest, a place for the aged, a place for the chemically dependent, or a place for convalescent, custodial, or educational care.

R.N.: A registered graduate nurse, other than a close relative, who is recognized, by the state in which care is given, as qualified to perform all nursing functions.

Remission: A halt in the progression of a terminal disease, or an actual reduction in the extent to which the disease has already progressed.

Respiratory Therapy: The treatment to preserve or improve pulmonary function.

Semi-Private: A two (2) bed room in a hospital. If the facility has no such rooms, the plan administrator will use the rate most commonly charged by similar institutions in the same geographic area.

Sickness: Any physical illness, mental illness, or pregnancy.

Skilled Nursing Facility: An institution which fully meets all of the following criteria:

Is operated in accordance with the applicable laws in the jurisdiction in which it is located;
Provides inpatient care and physical restoration services to those convalescing from illness or injury and helps them to meet a goal of self-care in daily living activities;
Overseen by a physician and operates under the supervision of a licensed physician, or registered graduate nurse (R. N.) who is devoting full time to such supervision;
Is regularly engaged in providing room and board, and continuously provides twenty-four (24) hour per day skilled nursing care by licensed nurses directed by a full-time registered graduate nurse (R.N.);
Maintains a complete medical record of each covered person who is under the care of a duly licensed physician;
Has a utilization review plan; and
Is not, other than incidentally, a rest home, a home for the aged, a place for custodial care or educational care, or a home for the chemically dependent, the mentally retarded or mentally ill.

Social Worker: This individual is a duly licensed, certified Social Worker with a least two (2) years or three thousand (3,000) hours of post-masters clinical social work practice in a clinical program established by the State Board of Social Work Examiners.

Sterilization: The process by which an individual is rendered incapable of procreation.

Supervising Doctor: The physician directing the Hospice Care Program.

Surgery: The branch of medicine which treats diseases, injuries, and deformities by incision or instrument operation or manual procedures.

Terminally Ill Person: A member of the family unit whose life expectancy is six (6) months or less, as certified by the primary attending physician.

TMJ: The abbreviation for temporomandibular joint syndrome.

Totally Disabled: (As regards Medical Coverage) A covered person shall be considered totally disabled if, as a result of an illness or an injury, s/he is unable to engage in any gainful occupation for which s/he is reasonably fitted by education, training, or experience, and is not able to perform work of any kind for wage or profit. A covered dependent will be considered totally disabled if s/he is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the New York Mental Hygiene Law; or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate, and who is unmarried, and who is chiefly dependent upon the covered person for support and maintenance.

Written, in writing: Signed, dated, and received at plan administrator in a form acceptable to the plan administrator.

GENERAL PROVISIONS

Submitting a Claim:

Written notice of a claim should be given to the plan administrator within 60 days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as is reasonably possible. Notice of a claim must be given within 15 months after the occurrence or commencement of any loss covered by the Plan. Notice, given by the covered person or on that individual's behalf, to the plan administrator at its office or to any authorized agent of plan administrator, with information sufficient for identification purposes, will be considered notice to the plan administrator.

The plan administrator, upon receipt of written notice of a claim, will furnish to the claimant the forms necessary for filing proofs of loss. If these forms are not furnished within 15 days after the claimant has given written notice, the claimant will be deemed to have complied with the requirement of the Plan as to proof of loss upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which a claim is made.

Failure to furnish the proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of the claimant's legal capacity, later than one year from the time proof is otherwise required.

The plan administrator processes benefits under the Plan when proof of loss is received. Claims are processed in order of the date received.

Choice of Provider:

The covered person has free choice of any provider.

Assignment:

The covered person may not transfer to anyone else ownership of any benefits herein.

Exam:

When reasonably necessary, the Plan may have the covered person examined while a claim is pending.

Legal Action:

Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of this Plan. Legal action must be taken within three (3) years after the date and proof of loss must be submitted.

Loss of Benefits:

The covered person must continue to be eligible as defined by the Plan. Failure to do so may result in the total loss of his/her benefits.

APPEALING A CLAIM

Claims Other Than Medical Necessity or Experimental/Investigational Services

This section describes the appeal process that applies to a claim denied, in whole or in part, for a reason other than a lack of medical necessity or the experimental/investigational nature of the service. (If a claim relates to medical necessity or the experimental/investigational nature of the service, please refer to the Section titled "Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure" for the applicable claim determination and appeal procedure.)

If a claim is denied in whole or in part, the covered person will receive notification of a claim denial via an explanation of benefits (EOB) form. The EOB form will be provided by the plan administrator. The EOB will show the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for the consideration of the claim, the plan administrator will request it.

If a covered person does not agree with the denial of a claim, the covered person may call the claims clerk on the toll-free number (1-800-499-1275). If the claim is not resolved to the covered person's satisfaction, the covered person should then speak to the manager of the plan administration office. At that point, a final determination will be made by the plan administrator. The covered person will be notified in writing of the plan administrator's determination. A review by the Executive Committee of the Plan and/or arbitration may be available; see the Sections titled "Review By the Executive Committee" and "Arbitration" below.

Review By the Executive Committee

If a covered person is not satisfied with an appeal determination regarding a claim that does not relate to a medical necessity or experimental/investigational services denial, the covered person may request a claim review by the Plan's executive committee by filing a written request for a review with the plan administrator. Upon receipt of a written request, copies of all pertinent information will be gathered and presented to the executive committee. The covered person may also submit written opinions and/or any comments regarding the claim to the plan administrator, who will include the information with the materials that are presented to the executive committee.

Requests for review by the executive committee should be filed promptly; however, requests may be filed at any time within 120 days of the final adverse determination by the plan administrator.

The executive committee will render its decision within 60 days of the receipt of the written request for review, unless specific circumstances warrant an extension. The decision of the executive committee pertaining to the review will be delivered in writing to the covered person, stating the specific reasons for the decision and the specific reference to the pertinent plan provisions upon which the decision is based.

Arbitration

If the covered person and/or the covered person's labor organization is not satisfied with the decision of the executive committee; and if the labor organization determines that the claim is meritorious and further appeal is in the best interests of the labor organization, the labor organization may submit the claim to arbitration, the outcome of which will be binding on all parties. The cost of the arbitration shall be divided equally between the Plan and the labor organization. The voluntary rules of the American Arbitration Association will apply, and a mutually acceptable arbitrator competent in the field of medical claims arbitration will be used.

Arbitration (Cont.)

If a covered person is not in a recognized bargaining unit, the written request for arbitration must be submitted directly to the plan administrator from the covered person. In such a case, the cost of the arbitration will be divided equally between the Plan and the covered person.

A request for arbitration must be submitted, in writing, to the plan administrator within 30 days of receipt of the written decision of the executive committee.

Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure
This section explains the utilization review (UR) procedure applicable to the Plan's decisions that relate to the medical necessity of care, including the appropriateness of the level of care or the provider of care; or to the experimental and/or investigational nature of care.

- Services will be deemed medically necessary only when all the following criteria are met:
    - **P**rovide for the treatment or diagnosis of an illness or injury, including premature birth, congenital and other birth defects;
    - **N**ecessary to meet a patient's basic health needs;
    - **A**ppropriate for the symptoms, consistent with the diagnosis, and in accordance with generally accepted medical practice and professionally accepted standards;
    - **N**ot recommended because it is more convenient for the patient, the physician, or other provider; and
    - **T**he most appropriate method of providing safe and adequate care.

Confinement in a hospital or other facility is considered medically necessary when the covered person needs to be confined because of the nature of the services that the covered person requires, or when treatment for the covered person's condition would be considered unsafe or inadequate if performed on an outpatient basis.

Treatment that is educational or done primarily for research will not be considered medically necessary.

A benefit payment will not be made if the plan administrator determines that the service, care, or supply was not medically necessary. However, the Plan will pay benefits if directed to do so pursuant to external appeal.

The fact that any particular physician or health care professional may prescribe, order, recommend, or approve service, supply or technology does not, in itself, make the services medically necessary.

The definition of medical necessity relates only to coverage and may differ from the way in which a provider engaged in the practice of medicine may define medical necessity.

Utilization Review Procedure

Given the voluntary nature of the Plan's managed care program, most of the UR procedures under this section including the pre-admission review process and the concurrent review process will not be applicable unless the covered person requests such a review.

UR decisions are made when a pre-admission review is requested for care (the "prospective review process"), a request is made for review of a case during the course of care (the "concurrent review process"), and after care is rendered (the "retrospective review process").

Examples of cases that would be reviewed under the UR procedure include a refusal of prior authorization for an inpatient hospital stay because the care is available on an outpatient basis; or a determination that a covered person can be released from a hospital because the covered person's condition no longer requires 24-hour nursing service; or a determination that the treatment received by a covered person is experimental and/or investigational, in light of the covered person's condition.

Utilization Review Procedure - Pre-Admission Review

The steps of the UR procedure are as follows:

1. **PRE-ADMISSION REVIEW PROCESS**

a. All requests for pre-admission review of care are reviewed to determine medical necessity (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is experimental and/or investigational. The initial review is performed by a nurse. If the nurse determines that the proposed care is medically necessary and not experimental and/or investigational, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

b. Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to the covered person, a designee authorized in writing by the covered person (if any), and the provider, by telephone and in writing, within three (3) business days of the request. If additional information is needed, it will be requested within 3 business days. You or your provider will then have 45 calendar days to submit the information. A notice of the determination will be provided to you (or your designee) and your provider, by telephone and in writing within three (3) business days of the earlier of our receipt of the information or the end of the 45-day time period.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will also describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation, if any, needed to make an internal appeal determination.

d. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within three (3) business days from the date of reconsideration. All of the information described in paragraph 1.c. above will be included in this notice.

2. **CONCURRENT REVIEW PROCESS**

a. When a covered person is receiving services and requests a concurrent review, a nurse will assess the medical necessity and experimental and/or investigational nature of services received throughout the course of treatment.

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary and not experimental and/or investigational. If so, the nurse will authorize the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). If additional information is needed, it will be requested within one (1) business day. You or your provider will then have 45 calendar days to submit the information. Failure to

Utilization Review Procedure - Concurrent review process (Cont.)

make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

c. You (or your designee) and the provider will be notified of the concurrent review decision, by telephone and in writing, within 1 business day of the earlier of the plan administrator's receipt of all information or documentation needed for the review or the end of the 45 day period.

d. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

e. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within 1 business day from the date of reconsideration. All of the information described in paragraph 2.d. above will be included in this notice.

3. **RETROSPECTIVE REVIEW PROCESS**

a. At the option of the plan administrator, a nurse will review retrospectively the medical necessity and the experimental and/or investigational nature of services, which are subject to utilization review. If the nurse determines that care received was medically necessary and not experimental and/or investigational, the nurse will authorize benefits. If the nurse determines that the care was not medically necessary or was experimental and/or investigational, the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

b. The covered person, an authorized designee, and the provider will be notified of the retrospective review determination, in writing, within 30 calendar days from receipt of the claim by the plan administrator. If additional information is needed it will be requested within 30 calendar days. Your or your provider will then have 45 calendar days to submit the information. A determination will be made and notice provided to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period..

c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to request a review of the adverse determination; give instructions for initiating standard, expedited, or external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

d. The provider who rendered care for which benefits are denied may request an internal appeal of the retrospective adverse determination on behalf of the covered person (even if not authorized in writing by the covered person to act as designee).

Utilization Review Procedure – Review of Adverse Determinations

4. **REVIEW OF ADVERSE DETERMINATIONS**

a. ***Request for internal appeal***

i. The covered person, an authorized designee, and, in a retrospective review case, the health care provider may request an internal appeal of an adverse determination, verbally or in writing, within 45 days from the date that notice of the adverse determination is received. (If the notice received does not specify all information required to conduct an internal appeal, the time period for appealing will be extended.) To submit an internal appeal verbally, the covered person, an authorized designee, or the provider may call 1-800-499-1275. To submit a written internal appeal, the covered person, an authorized designee, or the provider may write to the plan administrator.

ii. The procedure that will be followed in reviewing a case will differ, depending upon the urgency of the case. In most cases, a standard internal appeal, described in paragraph b. below, will be appropriate. In "urgent cases," an expedited internal appeal is available; expedited internal appeal is described in paragraph c. below.

b. ***Standard internal appeal***

i. The plan administrator will acknowledge an internal appeal in writing, within 15 calendar days after receiving it. The acknowledgment will identify the plan administrator (including the address and telephone number) as the person designated to respond to the appeal.

ii. When one or more internal appeals are received (for example, the covered person submits an appeal, then the health care provider submits an appeal on behalf of the covered person), a single internal appeal will be conducted by a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition) who did not make the initial adverse determination.

iii. The clinical peer reviewer will render a determination within 60 calendar days after receipt of all necessary information. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Written notice of the determination will be provided to the covered person and any other qualified party submitting an internal appeal, within 2 business days after the determination is made. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

iv. The notice will include detailed reasons and the clinical rationale for the determination. If the determination is adverse, the notice will describe the process, and enclose an application, for requesting an external appeal of the adverse determination. The external appeal process is described in paragraph d. below.

c. ***Expedited/Urgent Internal Appeal***

i. For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment; or any other issue with respect to which a provider requests an immediate review), the covered person, an authorized designee, or the provider may request an expedited

Utilization Review Procedure - Expedited Internal Appeal (Cont.)

internal appeal of the initial adverse determination. For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified for prospective; pre-service claims.

ii. When a request for expedited internal appeal is received, the appeal will be conducted by a clinical peer reviewer (defined in subparagraph b.ii. above) who did not render the initial adverse determination. Reasonable access to the clinical peer reviewer assigned to the appeal will be provided within 1 business day following receipt of notice of the request for appeal, to ensure that all relevant information is available to the clinical peer reviewer. Upon request, the covered person's provider and the clinical peer reviewer may exchange information by telephone or fax. If additional information is needed, it will be request within 24 hours of the appeal request. You or your provider will then have 48 hours to submit the information.

iii. In regards to concurrent reviews for urgent matters, if we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

iv. Within 24 hours of receipt by us of all information needed for the appeal, the clinical peer reviewer will render a determination on the expedited internal appeal. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

v. Notice will be provided to the covered person, an authorized designee, and the provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period. The notice will include all of the information described and enclosed in a notice of standard internal appeal determination (see subparagraph b. iv. above), and will describe the right to a standard internal appeal following an adverse determination on expedited internal appeal. The covered person, an authorized designee, and, where appropriate, the provider will be advised that, if a standard internal appeal is requested after the expedited internal appeal, the standard internal appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date of receipt of the final adverse determination notice upon completion of expedited internal appeal.

d. i. ***External appeal – Your right to an External Appeal***

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for Medical Necessity including appropriateness, health care setting, level of care or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases). You or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

Utilization Review Procedure - External Appeal (Cont.)

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

- The service, procedure or treatment must otherwise be a Covered service under the Policy and

- In general, you must have received a final adverse determination through our Internal Appeals Process. But, you can file an external appeal even though you have not received a final adverse determination through our Internal Appeal process if:

    - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or

    - You file an external appeal at the same time as you apply for an expedited internal appeal; or

    - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to your, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

ii. Your right to appeal a determination that a service is not Medically Necessary

If we have denied coverage on the basis that the service does not meet our requirements for medical Necessity, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal in **i**. above.

iii. Your right to appeal a determination that a service is Experimental or Investigational

If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal in **i**. above and your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which You are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested

Utilization Review Procedure - External Appeal (Cont.)

service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit out-weights the risk of the service. In addition, Your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the Nation Institutes of Health Rare Disease Clinical Research network or that it affects fewer than 200,000 U.S. residents per year.

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

iv. Your right to appeal a determination that a service is Out-of-Network

If we have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, you may appeal to an External Appeal Agent if you meet the two requirements for an external appeal in **i.** above, and you have requested preauthorization for the Out-of-Network treatment.

In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-network health service.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have the right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-network to provide the particular health service requested by you.

v. The External Appeal Process

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

We will provide an external appeal application with the final adverse determination issued through our Internal Appeal process or our written waiver of an Internal Appeal. You may also request an External Appeal application from the New York State Department of Financial Services at 1-800-342-3736. Submit the completed application to the Department of Financial services at the address indicated on the application. If you meet the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your External Appeal request. If the External Appeal Agent determines that the information you submit represents a material change form the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below), we do not have a right to reconsider our decision.

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

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an Expedited External Appeal. In that case, the External Appeal Agent must make a

Utilization Review Procedure - External Appeal (Cont.)

decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment we will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We 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 un this Policy for non-investigational treatment provided in the clinical trial.

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

We will charge you a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to you.

vi. Your Responsibilities

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

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or date upon which you receive a written waiver of any Internal Appeal, or our failure to adhere to claim processing requirement. We have no authority to extend this deadline.

COORDINATION OF BENEFITS

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan
This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Benefits Applies
This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays. This is to prevent payments from all group Plans from exceeding 100 percent of the total Allowable Expense.

Definitions
For purposes of this section, terms are defined as follows:
1. "Plan" is a form of coverage written on an expense- incurred basis with which coordination is allowed. "Plan" includes: group insurance and group remittance subscriber contracts; uninsured arrangements of group coverage; group coverage through HMO's and other prepayment, group practice and individual practice plans; and blanket contracts, except as stated below.

"Plan" includes the medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

"Plan" includes Medicare or other governmental benefits. However, "Plan" shall not include a State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

"Plan" does not include: individual or family:
(i) insurance contracts;
(ii) direct-payment subscriber contracts;
(iii) coverage through health maintenance organizations (HMO's); or
(iv) coverage under other prepayment, group practice and individual practice plans.

Plan shall not include blanket school accident coverage or such coverage issued to a substantially similar group where the policyholder pays the premium.

Each contract for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. A **"Primary Plan"** is one whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either:
   (i) the plan either has no order of benefit determination rules, or it has rules which differ from those included in this provision; or
   (ii) all plans which cover the person use the order of benefit determination rules included in this provision and under those rules the plan determines its benefits first.

There may be more than one Primary Plan (for example, two plans which have no order of benefit determination rules).

3. A **"Secondary Plan**" is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which their benefits are determined in

relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

4**. "Allowable Expense**" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Policy.
When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.
The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. **"Claim"** means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
(i) services (including supplies);
(ii) payment for all or a portion of the expenses incurred; or
(iii) a combination of subparagraphs (i) and (ii) of this paragraph.

6. "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect. During each Claim Determination Period Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:
(i) whether over-insurance exists; and
(ii) how much each plan will pay or provide.

As each Claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Order of Benefit Determination Rules
When two or more Plans pay benefits, the rules for determining the order of payment are as follows:
A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
(i) coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
(ii) any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

1. Non-Dependent or Dependent. The Plan that covers the person, other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

    a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if the parents are not separated or divorced. If both parents have the same birthday, the Plan that covered either of the parents longer is primary. If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

    b. If the parents are separated or divorced, the order of benefits is:
        1) The Plan of the custodial parent;
        2) The Plan of the spouse of the custodial parent; and then
        3) The Plan of the noncustodial parent.

    c. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

3. Active or inactive employee. The Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored, provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

4. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:
    a. a change in the amount or scope of a plan's benefits;
    b. a change in the entity which pays, provides or administers the plan's benefits; or
    c. a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

5. If a husband or wife is covered under this Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Plan, this means the Subscriber's benefit will pay first.

Effect on the Benefits of this

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, on a per claim basis, which were incurred by the person for whom the claim is made. As each claim is submitted, this Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine its obligation to pay for allowable expenses.

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. We may get the facts we need 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.

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

This Plan is primary and Medicare will be secondary in the event that one of the Medicare as secondary payer (MSP) rules, summarized in General Exclusion 4 of the "What the Medical Plan Does Not Cover" section, applies.

Otherwise, Medicare is primary and the Plan will be secondary. Medicare will be considered a plan for purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the covered person is actually receiving Medicare benefits.

For the purpose of coordination of benefits, the plan administrator or its agent:

May release to, or obtain from, any other organizations or individuals any claim information, and any individual claiming benefits under this Plan shall furnish the Plan Administrator or its agent with any information which may be required.

Has the right to pay to any other organization an amount it shall determine to be warranted, if payments which should have been made under this Plan have been made by such an organization under other plans.

Has the right to recover from other insurance companies, and/or other organizations such excess payment, if any overpayment is made under this Plan, from any individual to whom, or for whom, or with respect to whom such payments were made.

Note: Other group coverage will only terminate COBRA coverage if that other coverage does not include any "exclusion or limitation with respect to any pre-existing condition" of the qualified beneficiary.

MEDICARE ELIGIBLE EMPLOYEE COVERAGE

The following applies to an individual who is covered by the Plan and is also eligible for Medicare:

On the date an individual can be first covered for Medicare, the individual's medical benefit will be modified by the benefits available under Medicare, as explained later. However, if the individual:

Is an active employee age 65 or more;
Is a dependent spouse age 65 or more of an active employee; or
Has decided to retain this Plan as his/her primary coverage (see note below), the modification described later on this page will not operate. Instead, Medicare will adjust its benefits, as required by law, to take into account benefits payable under this Plan.

Note: Federal law gives an individual who is, or may be, covered under part A of Medicare solely on the basis of age, and is either an active employee, or the dependent spouse of an active employee, the right to elect Medicare, rather than this Plan's health care coverage as his/her primary coverage.

An individual who is, or will be, eligible for part A of Medicare must apply for part A (hospital insurance) and part B (supplementary medical insurance) of the Medicare program. The local Federal Government Department of Health and Human Services Office may be contacted for assistance in obtaining Medicare (part A and part B) insurance.

If Medicare benefits are paid for expenses not covered under the Plan, they will not be used to reduce benefits. In the case of services and supplies for which Medicare makes direct reimbursement to the provider, the amount of expense considered as approved charges by Medicare will be the charge utilized by the Plan when calculating benefits.

SITUATIONS AFFECTING PLAN BENEFITS

This section explains what happens to medical coverage in certain situations.

Termination of Employment

Coverage for employees under the Plan ends on the date specified in the employer's personnel policies and/or the applicable collective bargaining agreements. It also ends if the covered person is no longer eligible, or if the covered person stops the required premium contributions. However, continuation of coverage is available under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Coverage for covered dependents ends when they no longer meet the definition of a dependent (as described in the Section entitled ELIGIBILITY).

Personal Leave of Absence

If a covered person takes a personal leave of absence for any reason other than disability, his/her medical coverage and the coverage for any covered dependents may be continued, subject to the time limitations and conditions as set by the employer. Contact the specific municipality for additional information.

Medical Leave of Absence

If a covered person takes a medical leave of absence, his/her medical coverage and the coverage for any covered dependents may be continued, subject to the time limitations and conditions as set by the employer. Contact the specific municipality for additional information.

Converting Medical Coverage

If a covered person terminates his/her employment with a participating municipality and wants to continue his/her medical coverage and that of his/her covered dependents, the covered person may apply for continued coverage as explained in the section "Continuation of Coverage - COBRA."

Attachment of Benefits

To the extent permitted by law, all rights and benefits under this Plan are exempt from execution, attachment, garnishment, or other legal process for the covered person's debts or liabilities.

Discrimination Tests

The Plan is obliged by Federal law to assure that this Plan does not discriminate in favor of highly compensated employees. There are specific discrimination tests that must be applied to the Plan. If a Plan fails to satisfy the tests, highly compensated employees may be required to have their participation in the Plan limited or taxed for these benefits. The Plan will notify any highly compensated employees who may be affected by these tests.

CONTINUATION OF COVERAGE

Continuation of Coverage under COBRA

This section summarizes your rights and obligations with regard to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985and state continuation coverage laws as amended (commonly known as "COBRA").

In the event that a covered person is no longer covered under the Plan, the covered person will have the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates, if coverage terminates for one of the reasons specified below. The Plan will provide notice of the right to continue coverage, once notice has been received that an event triggering that right has occurred.

A covered person who is an employee of a participating municipality has the right to choose continuation coverage if coverage under the Plan terminates because of a reduction in hours of employment or due to voluntary or involuntary termination of employment or membership in the group/class (for reasons other than gross misconduct on the employee's part).

A covered spouse of an employee of a participating municipality has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following qualifying events:

1. the death of the employee;

2. the voluntary or involuntary termination of the covered employee's/member's employment or membership in the group/class

3. the reduction of hours worked by the covered employee/member.

4. a divorce or legal separation from the employee; or

5. the entitlement of the employee to Medicare.

A covered dependent child[1] of an employee of a participating municipality has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following qualifying events:

1. the death of the parent employed by the participating municipality;

2. the voluntary or involuntary termination of the covered employee's/member's employment or membership in the group/class with the participating municipality;

3. the reduction of the hours worked by the covered employee/member

4. the divorce or legal separation of the dependent child's parents;

5. the entitlement to Medicare of the parent employed by the participating municipality; or

6. the dependent child's ineligibility for coverage as a "dependent child" under the Plan.

Coverage may be continued for 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage. Coverage may be continued for 36 months in the event of termination or reduction in hours of employment. [1] A dependent child includes a newborn child, an adopted child, and a child placed with the covered employee for adoption, during the COBRA coverage period. The COBRA coverage period ends at the same time as the other family members.

Continuation of Coverage under COBRA (Cont.)

It is the responsibility of the covered person to notify the employee's participating municipality within 60 days of the date of a qualifying event, or the date the employee or member is sent notice by first class mail of the right to continuation by the group policyholder.

Continuation coverage may be cut short for the following reasons:

1. The employee's participating municipality no longer provides group health benefits coverage to any of its employees;

2. The covered person fails to make timely payment of any premium due;

3. After electing continuation coverage, the covered person becomes covered under another group health benefits plan that either: (i) does not contain any exclusion or limitation; or (ii) contains an exclusion or limitation that does not apply to the covered person or has been satisfied in accordance with federal law;

4. After electing continuation coverage, the covered person becomes entitled to Medicare; or

5. Continuation coverage has been extended for up to 29 months due to a covered family member's disability, and there has been a final determination that the family member is no longer totally disabled.

To continue coverage, the covered person must submit a written election form to the participating municipality within 60 days of the later of: (i) the date on which coverage terminates due to one of the events specified above; or (ii) the date notice is given by first class mail of the right to continue coverage under the Plan. If an election form is not returned by or on behalf of a covered person within that 60-day period, it will be assumed that s/he does not wish to continue coverage under the Plan.

If an election is made to continue coverage, a covered person will be required to pay the premium for the coverage. The premium payment will not exceed 102% of the group rate for the benefits, which includes a 2% administration fee. If desired, premiums may be paid on a monthly basis. The covered person will be required to pay the first premium payment in advance, along with any retroactive premium payments owed from the date of termination of coverage, within 45 days after submitting the written election form.

At the end of the COBRA continuation coverage period, a covered person may enroll in an individual conversion health benefits contract, as described elsewhere in the Plan.

Continuation of Coverage under New York State Law

If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law. Contact the participating municipality to find out if you are entitled to temporary continuation of coverage under COBRA or under New York law.

Under New York law, if a covered employee loses coverage because of termination of employment of membership in the class or classes eligible for coverage, the employee may continue coverage for him/herself and eligible dependents, subject to the following.

1. The covered person is not entitled to Medicare; and is not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions.

2. The covered person must request continued coverage within 60 days after the later of: the date of termination; or the date s/he is given notice of continuation by the participating municipality.

Continuation of Coverage under COBRA (Cont.)

3. The covered person must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date the covered person is given notice of continuation by the participating municipality. The premium cannot exceed 102% of the group rate.

4. Coverage will terminate at the earliest of the following:

   a. the date 36 months after the covered person's coverage would have terminated because of termination of employment or membership;
   b. The date to which premiums are paid, if the covered person fails to make a timely payment;
   c. If the covered person is an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; ineligibility for dependent child status under the Plan;
   d. The date you become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage that does not contain a pre-existing condition exclusion or limitation with respect you, your spouse or your children;
   e. The date 36 months after coverage would have otherwise terminated because of termination of employment or membership, if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in a. above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
   f. The date the participating municipality no longer provides coverage to any of its employees or members.

Continued Benefits after Termination for Total Disability under New York State Law

1. When Benefits May Be Continued. When a covered person is totally disabled, he or she may continue benefits for covered services to treat the total disability, if one of the following applies.

   a. *Termination of Employment, Eligibility, or Plan.* When coverage under this Plan ends because:

      i. the covered person is no longer actively employed;
      ii. the covered person is no longer eligible for coverage under the Plan; of
      iii. the Plan terminates;

      Coverage will be provided under the Plan during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay and/or surgery must be for treatment of the injury, illness, or pregnancy causing the total disability.

   b. *Termination of Active Employment.* If coverage ends because the covered person is no longer actively employed, benefits will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, illness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

Continuation of Coverage under New York State Law (Cont.)

2. When Continued Benefits End. The continued benefits will terminate when:

   a. the covered person has used all the Plan benefits available;

   b. the Plan Administrator determines that the covered person is no longer totally disabled;

   c. benefits are continued under a. above, and the covered person reaches the end of the 12-month period from the date coverage under this Plan ends.

The Plan will never pay more than the payments that would have been available, had a covered person remained covered under the Plan.

EMPLOYEE CONVERSION OPTION

When an employee's medical care coverage under this Plan terminates, the medical benefits may be converted to an individual policy.

The conversion privilege is available:

To an employee if his/her coverage terminates and s/he has been covered for at least three months under this Plan.

To a dependent spouse if the coverage terminates because of an employee's death, or because of divorce, or an annulment of marriage provided the dependent spouse is not a covered person under a similar individual health insurance policy or similar group health insurance policy or plan.

To an employee's dependent child(ren) if their coverage terminates because of the dependent's age, or because of an employee's death provided the dependent child(ren) are not covered person(s) under a similar individual health insurance policy or similar group health insurance policy or plan.

The conversion privilege is not available to any covered person who is eligible for Medicare. Application and payment of the first premium must be made to the insurance company designated by the employer within 45 days immediately following termination of insurance under this Plan. If continuation of coverage as described above is elected, this conversion option will apply at the end of the maximum continuation period thereunder.