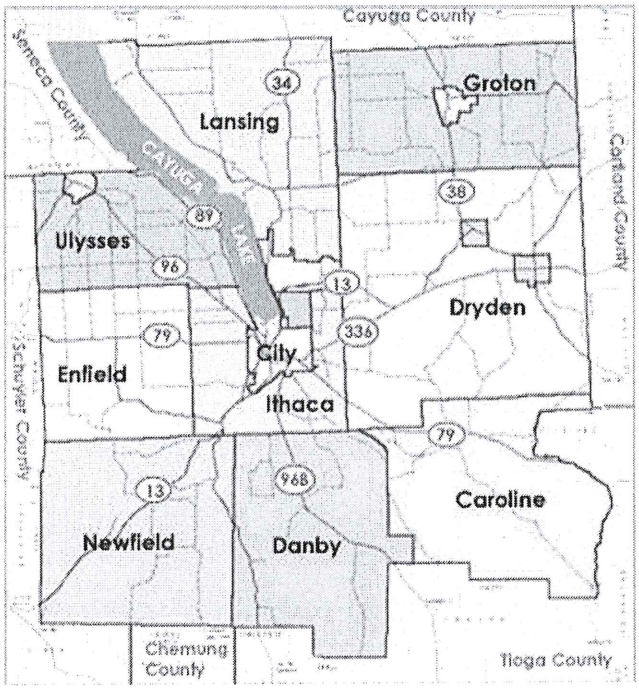
Greater Tompkins County Municipal Health Insurance Consortium



GTCMHIC Senior Plan

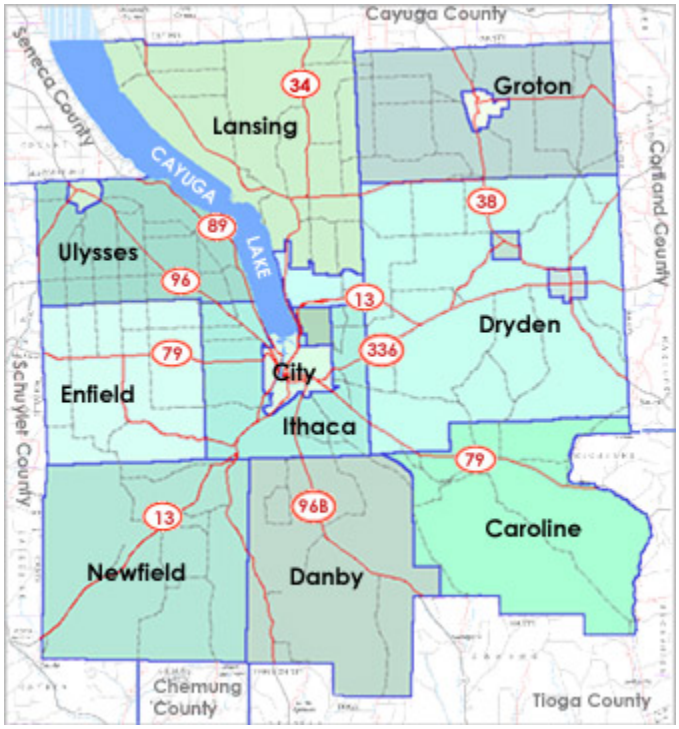
Greater Tompkins County Municipal Health Insurance Consortium Participants:

City of Cortland
City of Ithaca
County of Tompkins
Town of Caroline
Town of Danby
Town of Dryden
Town of Enfield
Town of Groton
Town of Ithaca
Town of Lansing
Town of Ulysses
Village of Cayuga Heights
Village of Dryden
Village of Groton
Village of Trumansburg

125 E. Court Street
Ithaca, NY 14850
(604) 274-5590

APPROVED
STATE OF NEW YORK
DEC 08 2015
Acting superintendent
Shirin Emami

Greater Tompkins County Municipal Health Insurance Consortium



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125 E. Court Street
Ithaca, NY 14850
(604) 274-5590

PLAN DOCUMENT

The Greater Tompkins County Municipal Health Insurance Consortium hereby establishes their Senior Health Benefits Plan, (the "Plan"), on the terms and conditions set forth in this Plan Document. This Plan is a policy of accident and health insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

EFFECTIVE DATE

The effective date of this Plan is January 1, 2016 as of 12:01 A.M. Eastern Standard Time at Ithaca, NY. Benefits payable by the Plan to eligible retirees on account of expenses incurred on or after the effective date shall be determined pursuant to the terms and conditions of this Plan.

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 two (2) years after the date, and proof of loss must be submitted.

PAYMENTS UNDER THE PLAN

Payments under the Plan for services provided by a participating provider will be made directly by the Plan to the participating provider. If services are received from a non-participating provider, the Plan reserves the right to pay either the covered person or the non-participating 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 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.

CONTRIBUTIONS

As dictated by an 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 enclosed 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
Table of Contents

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's Senior Plan. 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 January 1, 2016.

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 Claim Administrator, which processes all claims and makes benefit payments.

GENERAL INFORMATION

Plan Name

The Greater Tompkins County Municipal Health Insurance Consortium's Senior Plan (GTCMHIC Senior Plan).

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

Greater Tompkins County Municipal Health Insurance Consortium
125 E. Court Street
Ithaca, NY 14850
(604) 274-5590

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

Senior Retiree Plan

Type of Administration

Policy Administration

The Sources of Contributions to the Plan

Employer 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.

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

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

ELIGIBILTY

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.

Enrollment in this Senior Plan is available to a qualified Medicare enrolled retiree as defined by the Plan and each Municipality's Collective Bargaining Agreements, Personnel Policies and/or Legislative Resolutions.

Eligibility to be a Plan Participant in the "GTCMHIC Senior Plan" for an eligible retiree is from the first day that a member is Enrolled for Medicare Part A and Part B. Enrollment in this Plan will be accepted at any time after Medicare enrollment.

Additionally, Medicare enrolled retirees may elect coverage in this Senior Plan during Open Enrollment Periods as set forth in their employer's Collective Bargaining Agreements, Personnel Policies and/or Legislative Resolutions.

Enrollment in the GTCMHIC Senior Plan will not be discriminated in pricing or denied because of the health status, claims experience, receipt of health care, or medical condition of an applicant.

Retirees are prohibited from enrolling in this plan when covered by a Medicare Advantage Plan or if the retiree has a Medicare supplement insurance policy in force and is not seeking to replace the existing policy.

FUNDING

Cost of the Plan. The monthly participation contribution rates for coverage under the Plan are established by the Greater Tompkins County Municipal Health Insurance Consortium and the retirees Collective Bargaining Agreements.

Regular payment of Plan contributions is required. After the first payment, Plan contributions become due as they are billed. Claims will not be paid if premiums are not paid through the incurred date of the services for which the claims are submitted.

After the first payment, a deferral period of a full calendar month is allowed. If the Plan contribution is not paid within this deferral period, coverage is terminated retroactively to the last month for which Plan contributions were paid.

The level of monthly contributions is set by the Greater Tompkins County Municipal Health Insurance Consortium. The Greater Tompkins County Municipal Health Insurance Consortium reserves the authority to change the cost of the coverage. Should the rate change, the Greater Tompkins County Municipal Health Insurance Consortium will notify Plan Participants in writing at least 30 days before the change goes into effect.

ENROLLMENT

Enrollment Requirements. A Retired Medicare Enrollee must enroll for coverage by filling out and signing an enrollment application along with the appropriate deduction authorization, if applicable.

Retirees who are eligible for Medicare at retirement may elect to enroll in the Plan at retirement. Retirees who become eligible for Medicare by virtue of age after retirement may elect to enroll in the Plan at the time of Medicare enrollment.

Date of Coverage

The date coverage becomes effective for enrollees will occur on the first day of the month following the month in which the enrollment form is received by the plan administrator.

TERMINATION OF COVERAGE

Described below are the reasons why your coverage under this Plan may terminate. All terminations are effective at 12:01 a.m. on the date specified.

Termination of the Group Policy. This Plan is provided under the terms of the Group Policy between the GTCMHIC and your employer (Group policy holder). **The Group Policy is effective and will automatically be renewed each year unless it is terminated as set forth below.**

The group policy holder terminates the Group Policy pursuant to its terms. In this case, your coverage will terminate on the date the group policy terminates;

We do not receive premium payment from the group policy holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;

The group policy holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy. In this case, your coverage will terminate 30 days from the date we provide notice to you.

PLAN INFORMATION

GTCMHIC SENIOR PLAN

The Greater Tompkins County Municipal Health Insurance Consortium's Senior Plan is a plan that is comparable to coverage offered in a Medicare Supplemental Benefit Plan. The Plan is designed to fill in some of the coverage holes in Medicare Part A and Medicare Part B coverage. If you are not covered under Part A and Part B of Medicare, you are **not** eligible for coverage under this plan. **In addition Prescription Drug benefits may be available as a Rider to this coverage.**

NON-DUPLICATION OF MEDICARE BENEFITS

This Plan shall not duplicate any benefits provided by Medicare.

ALLOWED AMOUNT

The Plan will consider the Allowed Amount to be the Medicare Part A or Medicare Part B approved amount for those covered services billed by a covered provider. The Medicare approved amount is the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare approved amount also includes amounts considered payable under the Medicare Part B fee schedule. The Plan will not pay charges that exceed Medicare's approved amounts. For services covered under the Plan, and excluded under Medicare Part A or Medicare Part B, the Allowed Amount will be determined by the Claims Administrator as defined below. It is the Plan Participant's responsibility for payment of any charges that exceed the Medicare approved amounts or any ineligible claims.

For Services **Not Covered by Medicare** the "Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Policy before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for **Non-Participating Providers** will be determined as follows:

1. The Medicare amount unadjusted for geographic locality.

2. The Allowable Expense for services rendered by a Non-Participating Provider in connection with an Emergency Condition is the provider's charge.

MEDICAL NECESSITY

Except as otherwise listed, we will provide coverage for the services described in this Plan to the extent that the services are recognized as medically necessary by **Medicare**.

We will decide whether a **Service Not Covered by Medicare** was Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient

See the Utilization Review and External Appeal sections of this Policy for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

GUARANTEED BENEFITS

There will be not changes to the benefits described herein while the insurance is in force, except to change benefits designed to cover cost-sharing amounts under Medicare to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors, to amend the policy to meet minimum standards for Medicare supplement insurance, or to revise premium rates on a class basis.

OUT OF COUNTRY CARE

This Plan will provide benefits for Medically Necessary Emergency Care incurred outside the USA as shown in the Schedule of Benefit grid in this document. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. The Plan Participant is required to pay the provider at the time of service.

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 SECTION TITLED "WHAT THE MEDICAL PLAN COVERS".**

GTCMHIC SENIOR Plan		
Benefits	**Medicare A & B**	**GTCMHIC Senior Plan**
		Requires both Medicare A & B enrollment
WHO IS COVERED		
Type of Tiers	Single only	Single only
Dependent Coverage	No	No
Student Coverage	No	No
Domestic Partner Coverage	No	No
MEDICAL NECESSITY		As determined by Medicare
Pre-Cert Apply Y/N	N/A	N/A
Medical Benefit Management Program and Services	N/A	N/A
COST SHARING EXPENSES		
Policy Year	Calendar Year	Calendar Year
Deductible • Single	Changes Year to year Medicare A Medicare B	See specific benefit type
4th Quarter Deductible Care-Over	N/A	N/A
Copayment	Medicare A Medicare B Outpatient services	None
Coinsurance	20% Medicare B	See specific benefit type
Annual Out-of-Pocket Maximum	N/A	N/A
Lifetime Benefit Maximum	N/A	N/A
HOSPITAL INPATIENT SERVICES		
Inpatient Hospital Services	Medicare A deductible & copays Copay for 61st to 90th day. 60 Lifetime Reserve days (91st-150th day)	Covers Medicare A: Deductible Daily copay Lifetime Reserve copay When Medicare exhausts 100% of Medicare covered services up to 365 days per lifetime. Allowed amount is the amount Medicare allowed (not charge).
Mental Health Care Includes Partial Hospital State & Federal Mandate	Medicare A & B deductible & copays	Covers Medicare deductible & copays that may apply
Mental Health Care State Mandate for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Does not apply	Inclusive in Mental Health or Inpatient benefit as determined by Medicare
Residential Treatment	Not Covered	Not Covered

Benefits	Medicare A & B	GTCMHIC Senior Plan
Detoxification	Medicare A deductible and copays. Copay 61st to 90th day. 60 Lifetime Reserve days (91st-150th day)	Covers Medicare deductible & copays that may apply.
Skilled Nursing Facility	Medicare A covers: Days 1 – 20: Covered in full Days 21-100 Member pays up to daily allowance. There is a limit of 100 days in each benefit period.	Covers Medicare A: Deductible Daily Copay
Physical Rehabilitation	Medicare A deductible and copays Copay for 61st to 90th day 60 Lifetime Reserve days (91st-150th day)	Covers Medicare A; Deductible Daily copay Lifetime Reserve copay When Medicare exhausts 100% of Medicare covered services up to 365 days per lifetime.
Chemical Dependence and Abuse Rehabilitation	Medicare A deductible & copay Copay for 61st to 90th day 60 Lifetime Reserve days (91st-150th day)	Covers Medicare A; Deductible Daily copay Lifetime Reserve copay
Maternity Care	Medicare A deductible & copay Copay for 61st to 90th day 60 Lifetime Reserve days (91st-150th day)	Covers Medicare A; Deductible Daily copay Lifetime Reserve copay When Medicare exhausts 100% of Medicare covered services up to 365 days per lifetime.
Maternity Care-Routine Newborn Nursery	Not Covered	Not Covered
Internal Prosthetics	Medicare A deductible and copay	Covers Medicare A deductible and copays.
Blood – Part A & B Deductible	Medicare A & B deductible and coinsurance	Covers Medicare A & B deductible and coinsurance
HOSPITAL OUTPATIENT SERVICES		
Observation Stay	Medicare B deductible and Coinsurance	Covers Medicare B deductible and coinsurance
Surgical Care including Surgi-centers/Freestanding	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Pre-admission/Pre-operative Testing	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Diagnostic Imaging, X-ray, CAT, MRI	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Routine Imaging, X-ray, CAT, MRI (Benefit must be equal to Diagnostic)	Not covered	Not covered

Benefits	Medicare A & B	GTCMHIC Senior Plan
Diagnostic Lab and Pathology	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Routine Lab and Pathology (Benefit must be equal to Diagnostic)	Medicare B – Some preventive labs Covered in Full	Not covered
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Chemotherapy Therapy (excludes drugs dispensed by a pharmacy)	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Hemodialysis	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Screening Mammogram	Covered in full – once every 12 months – age 40 and over	Not covered unless Medicare deductible, coinsurance or copay applies
Diagnostic Mammogram	Medicare B deductible and coinsurance	Covers Medicare B copayment
Cervical Cytology	Medicare B - Covered in Full	Not covered unless Medicare deductible, coinsurance or copay applies
Mental Health Care	Medicare B deductible & Copayment between 20-40%	Covers Medicare B deductible, copay and coinsurance
Mental Illness-Biologically based/Children with Serious Emotional Disturbances	Not applicable	Inclusive in Mental Health or Office visit as determined by Medicare.
Chemical Dependency	Medicare B deductible & Copayment between 20-40%	Covers Medicare B deductible, copay and coinsurance
Covered Therapies (includes Physical, Speech and Occupational Therapy)	Medicare B deductible and coinsurance to annual $ limits	Covers Medicare B deductible and coinsurance
Pulmonary Rehabilitation	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Cardiac Rehabilitation	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Injectable Drugs (excludes vaccines, allergy injections and treatment of diabetes)	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
HOME CARE	Medicare A & B – Covered in full	Not covered unless Medicare deductible, coinsurance or copay applies. DME as part of Home Care – Medicare A or B coinsurance.
HOSPICE CARE	Medicare A – Covered in full • Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare A copay for outpatient prescription drugs. Medicare A coinsurance for respite care.
PHYSICIANS SERVICES		
Inpatient Hospital Surgery	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance

Benefits	Medicare A & B	GTCMHIC Senior Plan
Outpatient Hospital & Ambulatory Surgery	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Office Surgery	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Covered Therapies (includes Physical, Speech and Occupational Therapy)	Medicare B deductible & coinsurance to annual $ limits	Covers Medicare B deductible & coinsurance
Anesthesia (includes IP, OP, OV and delivery)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Additional Surgical Opinion	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Second Medical Opinion	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Maternity Care: Normal, Complications and Termination	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Prenatal and Postpartum Care	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Delivery Anesthesia	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
In-Hospital Physician Visits	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
PREVENTIVE SERVICES		
Routine Physical Exam – including routine labs done in conjunction with physical	Initial welcome to Medicare – covered in full within 1st 12 months of enrollment. Yearly wellness exams – covered in full	Not covered
Adult immunizations	Flu shots, pneumococcal and Hepatitis B – covered in full	Not covered unless Medicare deductible, coinsurance if applicable.
Eye Exams – Routine Eyewear – Frames/Lenses or Contact Lenses	Not covered Not covered	Not covered Not covered
Hearing Evaluations – Routine	Not covered	Not covered
Routine GYN Pelvic Exam including Cervical Cytology	Covered in full every 24 months	Not covered
Prostate Cancer Screening	Exam covered every 12 months - Medicare B deductible & coinsurance. Lab test covered in full	Covers Medicare B deductible and coinsurance if applicable
Bone Density Testing	Covered in full every 24 months if Medicare criteria is met	Medicare Part B deductible and Coinsurance if applicable
PHYSICIANS OFFICE SERVICES		
Office/Outpatient Consultations	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Diagnostic Office Visits	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance

Benefits	Medicare A & B	GTCMHIC Senior Plan
Diagnostic lab & pathology	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Routine Lab and Pathology (Benefit must be equal to Diagnostic)	Medicare B – Some preventive labs Covered in Full	Not covered
Eye exams – Diagnostic	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Hearing Evaluations - Diagnostic	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Hearing Aids	Not Covered	Not Covered
Diagnostic Imaging, X-rays, CAT, MRI, etc.	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Radiation Therapy (Excludes drugs dispensed by a pharmacy)	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Chemotherapy (Excludes drugs dispensed by a pharmacy)	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Hemodialysis	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Mammogram – Diagnostic	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Allergy Testing and Treatment (includes Serum and Injections)	Not covered	Not covered
Mental Health Care	Medicare B deductible & Copayment between 20-40%	Covers Medicare B deductible, copay and coinsurance
Chemical Dependency	Medicare B deductible & Copayment between 20-40%	Covers Medicare B deductible, copay and coinsurance
Chiropractic Care	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Injectable Drugs (excludes vaccines, allergy injections & treatment of diabetes)	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
ADDITIONAL BENEFITS		
Treatment of Diabetes (Insulin & supplies)	Medicare b deductible & coinsurance – Insulin not covered by Medicare B	Covers Medicare B deductible and coinsurance for supplies. Insulin not covered.
Diabetic Education	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Diabetic Equipment	Medicare B deductible and coinsurance	Covers Medicare B deductible and coinsurance
Durable Medical Equipment	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
External Prosthetics/Orthotics, including Foot Orthotics	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Medical Supplies	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Nutritional Therapy	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.

Benefits	Medicare A & B	GTCMHIC Senior Plan
Pre-hospital Emergency Services/Transportation – includes all ground transportation	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Air Ambulance Service	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Facility Emergency Room	Medicare B copayment	Covers Medicare B copayment
Emergency Room Physician Visit	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Freestanding Urgent Care Center	Medicare B copayment	Covers Medicare B copayment
Urgent Care Physician Visit	Medicare B deductible & coinsurance	Covered Medicare B deductible & coinsurance.
Medically Necessary Emergency Care in a Foreign Country	Not Covered	80% after $250 Deductible(CY) for necessary emergency hospital, MD and medical care that would be covered under Medicare if you received the care within the U.S.- $50,000 lifetime max
OTHER		
Acupuncture	Not Covered	Not Covered
Oral Surgery	Not Covered	Not Covered
Prescription Drugs	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Covered @ 80% of charge to a max of $100 day for 30 days per CY
Non-assigned provider	Not Covered	If the provider accepts Medicare's assignment the following will apply: • The balance will be covered when Medicare pays a percentage of the Medicare approved amount for a covered Part B service
EXCLUSIONS: The following are common exclusions that will apply:		
Cosmetic Services, Services related to Criminal Behaviors, Custodial Care, Dental Services, Free Care, Convalescent & Custodial Care, Services provided by Government Programs, Military Service-Connected Conditions, No-Fault Auto Insurance, Non-covered Services, Personal Comfort Services/Items, Routine Care of the Feet, Services before Coverage begins, Vision & Supplies, Workers Compensation		

WHAT THE MEDICAL PLAN COVERS

This section describes the covered medical benefits and how they apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Greater Tompkins County Municipal Health Insurance Consortium's Senior Plan. To receive benefits, a Plan Participant must be under a physician's care and the services must be recommended by the physician. These services are subject to the rules of the hospital or other covered institution, including regulations governing admission. Unless specifically shown as a covered benefit in this document, a Plan Participant is responsible for any ineligible charges or charges over the Medicare allowed amount.

COVERED CHARGES

Covered Charges are the Allowed Charges that are incurred for the following services and supplies. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

MEDICARE PART A – PLAN BENEFITS

When a Plan Participant is in a hospital and receives benefits under Part A of Medicare for that hospitalization, the Plan will pay the Medicare Part A deductible in each Benefit Period.

MEDICARE COINSURANCE AMOUNTS FOR HOSPITALIZATION UNDER MEDICARE PART A

When a Plan Participant is in a hospital and receives benefits under Medicare Part A for that hospitalization, the Plan will pay for the following:

(1) The Medicare coinsurance amount for the 61st through 90th day of each Benefit Period.

(2) The Medicare coinsurance amount for the Medicare 60 lifetime reserve hospital days.

ADDITIONAL HOSPITAL DAYS

If during a Benefit Period the Plan Participant has used the maximum Medicare hospital days, including Medicare lifetime reserve days, then the Plan will pay for medically necessary additional days of inpatient hospital care in the same Benefit Period. The Plan will not pay for more than 365 of such additional days during a Plan Participant's Lifetime.

The Plan's payment for each additional day of care will be limited to:

(1) those expenses that would have been paid under Medicare;

(2) short-term hospitalization in an acute care general hospital which either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of

Health Care Organizations or a national accreditation organization recognized by the Claims Administrator; and

(3) days for which Medicare would have made payments if the maximum Medicare days had not been used.

POST-HOSPITALIZATION SKILLED NURSING FACILITY CARE

When a Plan Participant is confined in a skilled nursing facility following hospitalization and receives Medicare Part A benefits for that confinement, the Plan will pay the coinsurance amount (patient liability) from the 21st day through the 100th day in each Benefit Period.

BLOOD DEDUCTIBLE UNDER MEDICARE

The Plan will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Medicare Part A or Medicare Part B each year, unless the blood is replaced in accordance with federal regulations.

HOSPICE CARE

The Plan will cover services that provide hospice care for those Plan Participants diagnosed with a terminal Illness provided:

(1) The Plan Participant is eligible for Medicare Part A (Hospital Insurance); and

(2) The Plan Participant's doctor and the hospice medical director certify that the Plan Participant is terminally ill and has 6 months or less to live if the Plan Participant's illness runs its normal course; and

(3) The Plan Participant gets care from a Medicare- approved hospice program.

Medicare will still pay for covered benefits for any health problems that are not related to the Plan Participant's terminal illness.

EMERGENCY CARE DURING FOREIGN TRAVEL

The Plan will cover emergency care in a foreign country (the Plan Participant must be legally responsible for payment of these services) under the following terms and conditions:

(1) The Plan Participant is a resident of the United States and is temporarily traveling elsewhere.

(2) Emergency care means care needed immediately because of an Injury or Illness of sudden and unexpected onset.

(3) The Plan will pay for those expenses for necessary emergency hospital, physician and medical care in a foreign country that would be covered under Medicare if care was received within the United States.

(4) The Plan will not pay for any emergency care received in a foreign country that is covered by Medicare under this benefit. If Medicare pays for the emergency care outside the USA, the Plan benefits will be limited to the Medicare Part A deductible and Medicare Part A and Medicare Part B deductible and coinsurance shown as covered under this Plan.

Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. The Plan Participant may be required to pay the provider at the time of service. If expenses outside the USA are incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service was rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Claims Administrator reserves the authority to reimburse the Plan Participant directly.

MEDICARE PART B – PLAN BENEFITS

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

When Medicare pays for a service covered under Medicare Plan B, the Plan will pay the coinsurance amount (patient liability), if any, based on the amount fixed by Medicare for the service. If Medicare pays 100% of the amount fixed by Medicare for a service covered under Medicare Part B, or Medicare determines the service is not an eligible expense, then the Plan will not provide payment. Under no circumstances will the Plan make any payments for the difference between the amount fixed by Medicare (Allowed Charge) and the actual charge to the Plan Participant for the service.

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

DEDUCTIBLES AND COPAYMENTS FOR MEDICAL SERVICES UNDER PART B OF MEDICARE

When you receive benefits covered under Part B of Medicare, we will pay for the following which Medicare does not pay:

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

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

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

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

NON-ASSIGNED MEDICARE CLAIMS

If your provider does not accept Medicare's assignment, our payment is different.

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

PRIVATE DUTY NURSING

We will provide coverage for Private Duty Nursing as an inpatient or in your home according to the benefits listed in the Benefit Summary.

PLAN EXCLUSIONS and LIMITATIONS

No coverage is available under this Policy for the following:

A. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

B. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Policy. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Policy unless medical information is submitted.

C. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly**.**

D. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Benefit Summary of this Policy, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

E. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

F. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

G. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

H. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Policy.

I. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

J. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

K. Services Not Listed.
We do not Cover services that are not listed in this Policy as being Covered.

L. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

M. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

N. Services with No Charge.
We do not Cover services for which no charge is normally made.

O. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses.

P. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Q. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law

CLAIM PROVISIONS

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Policy. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Policy for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting the Excellus website at www.excellusbcbs.com. Completed claim forms should be sent to the address on your ID Card or to Excellus BlueCross BlueShield of the Central NY Region, 333 Butternut Street, Syracuse, NY 13214-1803.

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

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

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

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

F. Pre-Service Claim Determinations.

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

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

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

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

UTILIZATION REVIEW PROCEDURES

The Provisions of this Section (Utilization Review Procedures) apply to Non-Medicare Covered services only. This Policy covers All services Covered by Medicare. Your Utilization Review for Medicare Covered Services is consistent with Medicare Guidelines.

Utilization Review

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

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website www.excellusbcbs.com.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided

within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period.

3.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

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

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

F. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of

receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

H. First Level Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

1. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

I. Second Level Appeal.
If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

J. Appeal Assistance.
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue
10 Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

GRIEVANCE and APPEAL PROCEDURES

The Provisions of this Section (Grievance and Appeal Procedures) apply to Non-Medicare Covered services only. This Policy covers All services Covered by Medicare. Your Grievance and Appeal Rights for Medicare Covered Services is consistent with Medicare Guidelines.

The Plan recommends that the Plan Participant keep a copy of all correspondence sent and received. There are established internal and external procedures to help a Plan Participant resolve a complaint related to the Plan Policies or the services provided. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

B. Filing a Grievance.
You can contact Us by calling the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave
10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

External Appeal

The Provisions of this Section (External Appeal) apply to Non-Medicare Covered services only. This Policy covers All services Covered by Medicare. Your appeal rights for Medicare Covered Services is consistent with Medicare Guidelines.

A. Your Right to an External Appeal.

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under this Policy; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of 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 You, 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).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If We have denied coverage on the basis that the service, not covered by Medicare, is not Medically Necessary You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. 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 (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. 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
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

D. 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) months 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 the first level of 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 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which 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 external 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 its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and 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 or an out-of-network 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 cost 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 the research, or costs that would not be Covered under this Policy for non-investigational treatments 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 $25for 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.

E. Your Responsibilities.

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

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

COORDINATION OF BENEFITS

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

A. Definitions.

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

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

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

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

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

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Policy will be primary.

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

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

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

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

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or

obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

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

1. If this Policy is primary, as defined in this section, We will pay benefits first.

2. If this Policy is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

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

RESPONSIBILITIES FOR PLAN ADMINISTRATOR

PLAN ADMINISTRATOR. The GTCMHIC Senior Plan is a Benefit Plan of the Greater Tompkins County Municipal Health Insurance Consortium, referred to as the Plan Administrator.

The Plan Administrator may appoint another entity to be Claims Administrator and serve at the convenience of the Plan Administrator.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator shall be conveyed to the Claims Administrator prior to becoming final and binding on all interested parties.

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the authority to remedy possible ambiguities, inconsistencies or omissions.
(**3**) To decide disputes in consultation with the Claims Administrator which may arise relative to a Plan Participant's benefit payments.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Claims Administrator to pay claims.
(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:
For Retired Employee Coverage: Funding is derived from the funds of the Employer and contributions made by covered Retired Employees. Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or the Claims Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the authority to recover the overpayment. The person or institution receiving the overpayment will be required to return money equal to the overpayment. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that a Plan Participant or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim will be denied and the Claims Administrator will recover any benefits paid to the Plan Participant and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. This paragraph does not affect the authority granted to the Plan Administrator and/or Claims Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

RECOVERY OF OVERPAYMENTS

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the benefit payments made on behalf of Plan Participants are limited to expenses Incurred prior to termination.

HIPAA COMPLIANCE

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information. A description of a Plan Participant's HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Employee covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Plan Participant. If a Plan Participant has a complaint, questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's HIPAA Privacy Officer at 615-741-4517 or 1-866-576-0029.

DEFINED TERMS

The terms used in this document that describe covered medical benefits carry the same meaning as those services defined under Medicare Part A and Medicare Part B.

The following terms have special meaning and when used in this Plan Document will be capitalized.

Allowed Charges The Plan will consider the Allowed Charge to be Medicare's Part A or Medicare's Part B approved amount for those covered services billed by a covered Provider. The Medicare approved amount is the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare approved amount also includes amounts considered payable under the Medicare B fee schedule. The Plan will not pay charges that exceed Medicare's approved amounts. For covered services under the Plan, and excluded under Medicare Part A or Medicare Part B, the Allowed Charge will be the amount determined by the Claims Administrator based on their contractual arrangements with providers. The Plan will not pay charges that exceed Allowed Charges. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

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

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

Claims Administrator Is the entity designated by the Greater Tompkins County Municipal Health Insurance Consortium to adjudicate claims under the plan of benefits; to respond to inquiries from employees, Retirees and Plan Participants; to exchange eligibility and claims payment information with Medicare and to perform other services as determined by the Greater Tompkins County Municipal Health Insurance Consortium and the Plan Administrator.

COBRA Means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) Means those services or supplies that are covered under this Plan, to include but not limited to, all services covered by Medicare Part A and Part B.

Employer Shall mean the Municipality under which an employee is eligible for benefits.

Enrollee Is a former employee who is enrolled for Medicare Part A and Part B who has retired from an eligible Employer and receives a benefit from an Employer participating in the Greater Tompkins County Municipal Health Insurance Consortium and participated in an optional retirement plan.

Incurred Means those services or supplies provided to or received by a Plan Participant. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

Injury Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. Injuries shall not include injuries for which benefits are provided under any State or Federal workers' compensation, employers' liability or occupational disease law, or benefits to the extent provided for any loss, proportion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.

Lifetime Is a word that appears in this Plan in reference to benefit maximums and limitations for Covered Charges. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medically Necessary/Clinically Necessary Shall mean services or supplies NOT covered by Medicare and covered under this Plan which are determined by a physician to be essential to health and are:

(A) Provided for the diagnosis or care and treatment of a medical, mental health/substance abuse or surgical condition;
(B) Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;
(C) Within standards of medical practice recognized within the local medical community;
(D) Not primarily for the convenience of the covered person, nor the covered person's family, physician or another Provider; and
(E) Performed in the most appropriate, cost effective and safe setting or manner appropriate to treat the covered person's medical condition. The fact that a physician has prescribed, performed, ordered, recommended or approved a service or treatment does not, in and of itself, make it medically necessary and appropriate. The Claims Administrator will determine if an expense is medically necessary and/or clinically necessary.

Medicare Is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Plan Means the Greater Tompkins County Municipal Health Insurance

Consortium's Senior Plan, a health benefits plan for eligible Retired Employees and is described in this document.

Plan Participant Is a former employee who meets the Plan's eligibility requirements, has applied for and qualified for coverage and who has paid the Plan premium. Plan Participants are certified by the Plan Administrator to the Claims Administrator.

Plan Year Is the 12-month period beginning on January 1 and ending on December 31.

Provider Means 1. Any legally licensed physician or any physical therapist, speech therapist, occupational therapist, or other health care providers performing a covered service ordered by a physician; 2. Any licensed independent laboratory, hospital, skilled nursing facility, rehabilitation facility, hospice agency, home health care agency; or other facility/agency included for Plan coverage; 3. Urgent care facilities and other health centers or clinics performing covered services given by covered physicians or other healthcare providers that would otherwise be covered by the Plan. To be covered, a Provider must meet criteria as a covered provider, meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Retired Employee or Retiree Is a former employee who has retired from the one of the participating municipalities within the Greater Tompkins County Municipal Health Insurance Consortium.

Special Qualifying Event Is a personal change in status, such as divorce or termination of spouse or ex- spouse's employment, which may allow persons to enroll or change benefit elections.

Total Disability (Totally Disabled) Is the complete inability as a result of Injury or Sickness for an individual to perform the normal activities of a person of like age and sex in good health.

Tricare Is the United States Department of Defense health care program for members of the uniformed services, their families and survivors.