DEPENDENT COVERAGE
Coverage is provided for the following dependents:

Spouses
Legal spouse (includes legally separated but not divorced spouse).

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

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

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

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

    1. The affidavit must be notarized and must contain the following:

        a. The partners are both eighteen years of age or older and are mentally competent to consent to contract.

        b. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York

        c. The partners have been living together on a continuous basis prior to the date of the application; and

    2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

    3. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:

        a. A joint bank account
        b. A joint credit card or charge card
        c. Joint obligation on a loan
        d. Status as an authorized signatory on the partner's bank account, credit card or charge card
        e. Joint ownership of holdings or investments
        f. Joint ownership of residence
        g. Joint ownership of real estate other than residence
        h. Listing of both partners as tenants on the lease of the shared residence
        i. Shared rental payments of residence (need not be shared 50/50)
        j. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
        k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
        l. Shared household budget for purposes of receiving government benefits
        m. Status of one as representative payee for the other's government benefits

n. Joint ownership of major items of personal property (e.g., appliances, furniture)
o. Joint ownership of a motor vehicle
p. Joint responsibility for child care (e.g., school documents, guardianship)
q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
r. Execution of wills naming each other as executor and/or beneficiary
s. Designation as beneficiary under the other's life insurance policy
t. Designation as beneficiary under the other's retirement benefits account
u. Mutual grant of durable power of attorney
v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
w. Affidavit by creditor or other individual able to testify to partners' financial interdependence
x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

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

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

Children (natural or legally adopted, or pre-adopted) who are under the age of 26:
Coverage lasts until the end of the month in which your child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as a full time student; or unmarried.

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

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

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

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

Children

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

Young Adult Option:

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

Parent:

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

Young Adult:

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

Premium – Cost of coverage:

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

Your Child may elect this Coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment;
3. During an annual 30-dy open enrollment period, in which case coverage will be prospective and will start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment; and
4. During an initial 12-month open enrollment period, commencing on the first renewal of the policy on or after September , 2009, in which case coverage will be prospective and start within 30 days of when the group contract holder or group contract holder's designee receives notice of election and premium payment.

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

ALL OTHER PERSONS ARE EXCLUDED FROM COVERAGE UNDER THIS PLAN.

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

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

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

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

This continuation stops on the earliest of the following dates:

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

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

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

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

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

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

PROVISIONS RELATED TO QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Purposes

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

Definitions

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

A Medical Child Support Order to be qualified must clearly:

1. Specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order;
2. Include a reasonable description of the type of coverage to be provided by the Plan to each alternative recipient, or the manner in which such type of coverage is to be determined;
3. Specify each period to which such order applies; and
4. Specify each plan to which such order applies.

A Medical Child Support Order to be qualified must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirement described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

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

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

2. **P**ermit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order.

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

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

Medicare Eligibility

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