

ST. LAWRENCE COUNTY HEALTHCARE PLAN



SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE

JANUARY 1, 2002 - MANAGEMENT & CONFIDENTIAL / JAIL DEPUTIES

MARCH 1, 2002 – CSEA

DECEMBER 1, 2003 – SHERIFFS DEPUTIES

Revision Date: January 1, 2004

SUMMARY PLAN DESCRIPTION

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SUMMARY PLAN DESCRIPTION INTRODUCTION

Summary Plan Description Overview

This document is a Summary Plan Description of the health benefits of the St. Lawrence County Employees Health 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 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 with the Director of Central Services of St. Lawrence County.

The benefits described in the Summary Plan Description are in effect as of January 1, 2002.

Plan Costs

The St. Lawrence County Employees Health Plan is a self-funded plan. Contributions from the County and payroll deductions are used to pay the benefits that are claimed against the Plan. The Plan is administered by APA Partners, Inc., which processes all claims and makes benefit payments.

Plan Effective Date

The effective date of this Plan is January 1, 2002.

GENERAL INFORMATION

PLAN NAME THE ST. LAWRENCE COUNTY EMPLOYEES HEALTH PLAN

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

County of St. Lawrence
48 Court Street
Canton, NY 13617-1169
(315) 379-2210

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 County Administrator designated by the County's Board of Legislators. The name and address of the Attorney-in-Fact are available from the Plan Administrator at the address and telephone number above.

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

Type of Plan Group Health Benefits Plan

Type of Administration Contract Administration

The Sources of Contributions to the Plan Employer and Employee contributions

Plan Year

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

Plan Modification

The Plan may be modified or amended from time to time and such modifications which would affect covered participants will be communicated to Plan Participants.

GENERAL INFORMATION

Plan Supervisor (Third Party Administrator - TPA)

The person providing consulting services to the employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

The Plan Supervisor / TPA is:

Resolve Health Plan Administrators of the North Country, LLC
555 West Granada Blvd, Ste B3
Ormond Beach, FL 32174
(877) 880-4380

ELIGIBILITY

Eligible Employees

An employee of a bargaining unit, and the employee's dependent(s), must be offered the opportunity to enroll in the Plan subject to the contract language of the collectively bargained agreement in place for that employee's bargaining unit. A non-union management employee, and the employee's dependent(s), must be offered the opportunity to enroll in the Plan subject to County Board Resolution.

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

Date Coverage Begins

Coverage will begin for an eligible employee on the first day of the month following the date of employment, if enrolled in the Plan on or before that date. An employee will be deemed to have enrolled when a completed and signed Enrollment Form has been received by the Plan Administrator along with any required contributions.

If an eligible employee is not actively at work on the date coverage would otherwise become effective, coverage shall become effective on the day the employee returns to active work.

Coverage for Employees that are Called to Active Military Service

Health insurance will continue for those on paid Military Leave as if you were an active employee. Any deductions for premium contributions will also continue during this period. In that the Federal Government provides individual coverage for those on active duty, while a County employee is on paid military leave, they would have both County and Federal Coverage. If on unpaid Military Leave, the employee would have coverage through the Federal Government Program only.

Coverage for dependents of employees enrolled for family coverage will remain covered as long as the associated family premium contribution is paid. If the employee is receiving a payroll check, their premium contribution will continue to be deducted at the active rate. An employee may elect to use their vacation and personal leave accruals in order to keep their insurance premium contributions at the active rate. Once the employee goes on unpaid Military Leave, the employee will receive notification of the status change and will be

asked whether or not they wish to continue health insurance coverage at the active rate for up to 12 months from their activation date.

When all appropriate accruals are exhausted, the employee will be placed on unpaid Military Leave and after 12 months from their activation date, they will be billed at the leave of absence rate, which is the full premium. The leave of absence rate is the full current premium equivalent rate for the County Health Insurance Plan, not just the employee's share of the premium contribution. Due to the fact that the full premium equivalent rate is substantially higher than the active premium contribution, the employee should research healthcare coverage from the Federal Government in order to make an informed decision concerning whether or not to continue coverage at the Leave of Absence Rate.

Termination of Coverage

Coverage for an employee and dependent(s) will terminate on the earliest of the following dates:

Employee:

- The last day of the month in which employment terminates;
- Date the employee ceases to be in a class eligible for coverage;
- Date the employee fails to make any required contribution for coverage;
- Date the Plan is terminated.

Dependent:

- Date the dependent ceases to meet eligibility requirements of the plan;
- Date employee coverage terminates under the plan;
- Date the employee fails to make required contribution for dependent coverage;
- Date Plan is terminated.

Retiree Eligibility

An employee may continue benefits after retirement by making premium contributions, and meeting the following requirements:

- Completion of at least five (5) years of continuous service, with St. Lawrence County; and
- Qualification for retirement as a member of New York State Retirement System or one of its civil divisions; **or**
- Not a member of the New York State Retirement System, but has completed at least five (5) years of continuous service and is at least 55 years of age.

Employees who have qualified for NYS Retirement Disability Payments may be

considered to be retired for purpose of retiree eligibility under this Plan regardless of age, provided that they have had at least 10 years of service with St. Lawrence County.

All employees who qualify for retirement benefits from the County are eligible for coverage only to the extent of coverage they carried on the day prior to retirement. Dependents of retirees who are not covered by the Plan prior to the employee's retirement are not eligible dependents.

Survivor's Coverage

When an employee or retired employee dies, coverage for his/her dependents who were covered by the Plan at the time of the employee's / retiree's death shall continue for (1) month beyond the last day of the month of the date of death. The survivor shall be responsible for 100 % of the monthly premium equivalent for such coverage. The spouse, provided he/she does not remarry, and dependent children of deceased employees / retirees who had ten or more years of service, may continue coverage under the Plan by paying the full cost of the coverage.

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

Dependent Coverage

Coverage is provided for the following dependents:

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

Unmarried dependent child (natural or legally adopted) is eligible from birth if the child is:

Less than age 19, or if a **full-time student** at an accredited secondary or preparatory school or college or other accredited educational institution, less than age 23. Coverage periods for students will be from February 1 through September 30, and October 1 through January 30. Coverage automatically ends if a student verification form is not submitted every semester;

Full-time students shall be registered for not less than 12 course credit hours per semester. If the institution establishes full-time student status by a method other than semester credit hours, we reserve the right to determine whether the student qualifies as a Dependent.

Dependent on, and is legally in the custody of the covered person for financial support and maintenance; and

Not married.

Other dependent children, provided they reside with and are dependent upon the covered person for financial support and maintenance, if the dependent is:

An unmarried child 19 years of age or older who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the New York Mental Hygiene Law; or physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate and who is chiefly dependent upon the covered person for support and maintenance. To continue a child under this provision, proof of incapacity must be received by the Plan Administrator within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time;

A step-child; or

A child for whom the covered person is the legal guardian.

Children ordered to be covered by a court decree are also eligible for coverage.

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 explanation that will be reviewed and decided upon by the Plan Administrator prior to the dependent's enrollment in the Plan. In certain circumstances, the Plan Administrator may require a Court Decree to document dependence.

If both husband and wife are employed by the County and both are eligible for dependent coverage, either the husband or wife, but not both, may elect dependent coverage for their eligible dependents.

When Dependent Coverage Stops

Dependent coverage normally stops when the dependent relationship ends or when the covered person's coverage ends. 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 (Page 91).

Any person who is in full-time military, naval or air force service cannot be a dependent.

ALL OTHER PERSONS ARE EXCLUDED FROM COVERAGE UNDER THIS PLAN.

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. Proof of the incapacity will be required from time to time to keep this coverage in effect. Determination of dependent eligibility is solely the responsibility of the Plan Administrator.

This continuation stops on the earliest of the following dates:

The date on which the dependent is no longer incapacitated according to the Plan Administrator;

The date proof of the dependent's incapacity is not provided at the request of the Plan Administrator;

The date the dependent's coverage stops because of another Plan Provision.

Enrollment Changes

A covered person may change benefit coverage at any time.

To avoid problems and possible loss of benefits, be sure to notify your Plan Administrator, when any of the following occurs:

- You or your spouse attain an age of 65 and become eligible for enrollment in Medicare,
- You or a covered dependent become eligible for Medicare benefits due to a disability,
- Your spouse dies,
- You no longer have children eligible for coverage by virtue of age (19) or student status,
- You have a disabled dependent who reaches age 19,
- You are single, divorced, or widowed and enrolled for individual coverage but become married and desire family coverage.

Provisions Related to Qualified Medical Child Support Orders

Purposes

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

Definitions

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

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

- Provides for child support for a child of a covered person under a group health plan, or

Provides for health coverage to such a child under state domestic relations law (including a community property law), and

Relates to benefits under this Plan.

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

Qualified Medical Child Support Order (QMCSO)

A Medical Child Support Order to be qualified must clearly:

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

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

Specify each period to which such order applies; and

Specify each plan to which such order applies.

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

Procedures

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

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

Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical

Child Support Order.

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

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

Medicare Eligibility

Details pertaining to Medicare eligibility can be found on [Page 88](#).

PLAN INFORMATION

The Plan has contracted with a group of Physicians, Hospitals, and other Ancillary Providers who may be used by covered persons to provide most of the covered applicable services described in this Summary Plan Description. A list of the participating providers can be found in the Directory of Participating Providers.

A covered person under this Plan is eligible to receive care from any participating provider. It is recommended that a member verify a provider's participation prior to seeking services by contacting the Plan's Third Party Administrator at (518) 786-2870 or (800) 833-3650.

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

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

A covered person will not be billed for the balance of any covered services in excess of the co-payment.

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

There are separate payment levels under this Plan for participating and nonparticipating providers. The benefits for participating providers are generally higher than those for nonparticipating providers. The benefit amounts and limits with respect to covered services by both participating and nonparticipating providers are shown in the section entitled BENEFIT SUMMARY (Pages 17-33).

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

Co-Payments

Covered persons must pay applicable co-payments as outlined in the Benefit Summary Section. There is a maximum of (1) one co-payment per visit.

Out-of-Area Coverage

For out-of-area services, the Plan has contracted with large national provider network(s), to provide the covered person with the opportunity to receive in-network benefits for services performed in areas not within the local network.

To ensure access to in-network benefits, a listing of participating providers and facilities in a specific area will be forwarded upon request to the covered person by contacting the Plan's Third Party Administrator at (518) 786-2870 or (800) 833-3650.

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

Out-Of-Network Deductible & Coinsurance

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

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

The co-payments that the covered person pays for in-network services, and any amounts paid by the Plan for in-network services, will not be applied toward reaching the deductible. The deductible amount must be satisfied once each calendar year except for:

The Common Accident Provision - If two or more members of one family incur covered expenses because of injuries sustained in any one

accident, the deductible amount will be applied only once with respect to all covered expenses incurred as a result of the accident.

Out-Of-Pocket Maximums

The benefit payment for out-of-network covered services that are subject to coinsurance will increase to 100% of the 90th percentile of the usual, customary and reasonable fees for the given area as determined by Ingenix, less any applicable deductible for each covered person during the calendar year, after:

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

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

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

UCR Amount

The Plan has set the UCR Amount at the 90th percentile of the usual, customary and reasonable fees for the given area as determined by Ingenix. For any services performed by an out-of-network provider, the covered person is responsible for any charges in excess of the UCR Amount.

Because of this, the Plan strongly encourages people to discuss, in advance, whenever possible, with providers the cost of their services. Upon request of the covered person, the Plan's Third Party Administrator will assist in determining the amount, if any, of the charges that are in excess of the UCR Amount. In addition, the Plan's Third Party Administrator will assist the covered person in attempting to negotiate with out-of-network providers to limit the financial exposure the covered person may have. However, the Plan cannot

guarantee that there will be no amounts payable in excess of the UCR Amount for the out-of-network providers.

Maximum Benefit

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

Weekend Admission Exclusion

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

Transition of Care

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

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

BENEFIT SUMMARY

*** THIS SECTION PROVIDES A SUMMARY OF THE PLAN BENEFITS. PLEASE BE SURE TO REFER TO ALL APPROPRIATE SECTIONS IN THIS SUMMARY PLAN DESCRIPTION FOR A COMPLETE DESCRIPTION OF THE BENEFITS PROVIDED BY THE PLAN. IN PARTICULAR, PLEASE REFER TO THE SECTIONS TITLED "WHAT THE MEDICAL PLAN COVERS" (PAGES 34-58), AND "WHAT THE MEDICAL PLAN DOES NOT COVER" (PAGES 59-65).

Eligibility

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

Pre-Existing

There is no exclusion for pre-existing conditions.

UCR Amount

For any services performed by an out-of-network provider, enrollees are responsible for any charges in excess of the UCR Amount. The Plan has set the UCR Amount as the 90th percentile of usual, customary and reasonable fees for the area the service is provided in as determined by HIAA. Because of this, the Plan strongly encourages individuals to discuss, in advance, whenever possible, with out-of-network providers, the cost of their services. The Plan Administrator will be able to assist in determining the amount, if any, of the charges that are in excess of the UCR Amount.

BENEFIT SUMMARY	
BENEFIT FEATURES:	BENEFIT PAYMENT
IN-NETWORK	OUT-OF-NETWORK
BENEFIT PAYMENT	BENEFIT PAYMENT
Allergy Treatment	
Office Visit	After deductible
The Plan pays: 100% of contracted rate minus co-pay	80% of UCR Amount
The covered person pays: \$10 co-pay	20% of UCR Amount and any remaining balance
Injection Only	After deductible
The Plan pays: 100% of contracted rate	80% of UCR Amount
The covered person pays: 0% of contracted rate	20% of UCR Amount and any remaining balance
Ambulance (Including professional and volunteer)	
The Plan pays: 100% of contracted rate minus co-pay	After deductible
The covered person pays: \$10 co-pay	80% of UCR Amount 20% of UCR Amount and any remaining balance

BENEFIT SUMMARY	
BENEFIT FEATURES:	BENEFIT PAYMENT
IN-NETWORK	OUT-OF-NETWORK
BENEFIT PAYMENT	BENEFIT PAYMENT
Ambulatory Surgery (Including outpatient surgery)	
The Plan pays: 100% of contracted rate minus co-pay	After deductible
The covered person pays: \$10 co-pay	80% of UCR Amount 20% of UCR Amount
Anesthesia (In and outpatient)	
The Plan pays: 100% of contracted rate	After deductible
The covered person pays: 0% of contracted rate	80% of UCR Amount 20% of UCR Amount and any remaining balance
Assistant Surgeon	
The Plan pays: 100% of contracted rate	After deductible
The covered person pays: 0% of contracted rate	80% of UCR Amount 20% of UCR Amount and any remaining balance

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

Chemical Dependence

Inpatient (Limited to 30 days per confinement, two confinements per calendar year including partial hospitalization with the total benefit not to exceed \$450 per day)
(Detox limited to 7 days maximum per confinement)
After deductible

The Plan pays: 100% of contracted rate minus co-pay 80% of UCR Amount
The covered person pays: \$100 co-pay 20% of UCR Amount
and any remaining balance and any remaining balance

Outpatient (Benefit limited to 60 visits per calendar year with the total benefit not to exceed \$100 per visit)
(Up to 20 of the 60 visits may be used for family counseling)
After deductible

The Plan pays: 100% of contracted rate minus co-pay 80% of UCR Amount
The covered person pays: \$10 co-pay 20% of UCR Amount
and any remaining balance and any remaining balance

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

Chiropractic Care

(Benefit limited to 20 visits per year if medical necessity)
After deductible

The Plan pays: 100% of contracted rate minus co-pay 80% of UCR Amount
The covered person pays: \$10 co-pay 20% of UCR Amount
and any remaining balance

Dental

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

The Plan pays: 100% of contracted rate minus co-pay 80% of UCR Amount
The covered person pays: \$10 co-pay 20% of UCR Amount
and any remaining balance

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

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

The Plan pays: 100% of contracted rate
The covered person pays: 0% of contracted rate
After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Diagnostic Lab and X-ray

The Plan pays: 100% of contracted rate
The covered person pays: 0% of contracted rate
After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Dialysis

The Plan pays: 100% of contracted rate
The covered person pays: 0% of contracted rate
After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

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

Durable Medical Equipment (Including orthotic devices)

(For rental of DME, the co-pay will be applied once per year, or per course of treatment, whichever is less)

The Plan pays: 100% of contracted rate minus co-pay
The covered person pays: \$20 co-pay
After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Gynecology

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

The Plan pays: 100% of contracted rate
The covered person pays: 0% of contracted rate
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Home Health Care

(Maximum benefit limited to 60 visits per calendar year)
(Four hours of care constitutes one home health aid visit)

The Plan pays: 100% of contracted rate minus co-pay
The covered person pays: \$10 co-pay
After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

BENEFIT SUMMARY		
BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	
BENEFIT FEATURES:	OUT-OF-NETWORK BENEFIT PAYMENT	
Hospice Care	(Care for terminally ill; benefit limited to 210 days maximum per lifetime - bereavement counseling limited to the immediate family of the hospice patient and is limited to five days)	
The Plan pays:	100% of contracted rate	After deductible
The covered person pays:	0% of contracted rate	80% of UCR Amount
		20% of UCR Amount
		and any remaining balance
Hospital Emergency Room Care	(The New York State emergency care mandate applies to this benefit) (Should a covered person require more than one emergency room visit for the same illness/injury within a 48 hour period, only one co-payment will be required)	
<u>ER Visit Does Not Meet the Emergency Criteria</u>		
The Plan pays:	100% of contracted rate minus co-pay	100% of contracted rate minus co-pay
The covered person pays:	\$50 co-pay (Waived if admitted)	\$50 co-pay (Waived if admitted)
<u>ER Visit Does Meet the Emergency Criteria</u>		
The Plan pays:	100% of contracted rate minus co-pay	100% of contracted rate minus co-pay
The covered person pays:	\$10 co-pay (Waived if admitted)	\$10 co-pay (Waived if admitted)

Benefit Summary		
BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	
BENEFIT FEATURES:	OUT-OF-NETWORK BENEFIT PAYMENT	
Hospital Room & Board		
The Plan pays:	100% of contracted rate minus co-pay	After deductible
The covered person pays:	\$0 co-pay	80% of UCR Amount
		20% of UCR Amount
		and any remaining balance
Mammograms	(Per physician recommendation, and/or routine mammograms covered once every calendar year for ages 35 and over)	
The Plan pays:	100% of contracted rate	After deductible
The covered person pays:	0% of contracted rate	80% of UCR Amount
		20% of UCR Amount
		and any remaining balance
Maternity	(Including prenatal, delivery, and post-partum care) (This benefit is for the physician's services, any applicable hospital charges would apply to the inpatient delivery)	
The Plan pays:	100% of contracted rate minus co-pay	After deductible
The covered person pays:	\$10 co-pay for initial visit only Remaining visits paid in full	80% of UCR Amount
		20% of UCR Amount
		and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Maternity (continued) <u>Birth Center and Midwife</u> The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
Medical Supplies The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
Newborn Baby Care (Facility and professional charges) The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
Organ/Tissue Transplants The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Services INCLUDES: <u>Office/Home Visits</u> The Plan pays: 100% of contracted rate minus co-pay The covered person pays: \$10 co-pay		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
<u>Diagnostic X-ray/Labs</u> The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
<u>Inpatient Hospital Visit</u> (Benefit limited to one visit per day) The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance
<u>Inpatient Consultation</u> (Benefit limited to one visit per day) The Plan pays: 100% of contracted rate The covered person pays: 0% of contracted rate		After deductible 80% of UCR Amount 20% of UCR Amount and any remaining balance

BENEFIT SUMMARY

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

The Plan pays: 100% of contracted rate minus co-pay
 The covered person pays: \$10 co-pay

Pre-Admission Testing (Must be done within 7 days prior to admission)

The Plan pays: 100% of contracted rate
 The covered person pays: 0% of contracted rate

Prescription Drugs (See Pages 34 - 35 for exclusions)

Retail Pharmacy (30 day supply only):

The covered person pays: \$ 5 per generic prescription
 The covered person pays: \$15 per brand name prescription if generic is available
 The covered person pays: \$10 per brand name prescription if no generic is available

After deductible

80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

After deductible

80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
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Prescription Drugs (continued)

Mail-Order Pharmacy – Maintenance Medications Only (90 day supply):

The covered person pays: \$ 2 per generic prescription
 The covered person pays: \$ 5 per brand name prescription

Preventive Care

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

The Plan pays: 100% of contracted rate minus co-pay
 The covered person pays: \$10 co-pay

After deductible

80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

Well-Child Care (up to the 19th birthday including immunizations) (as per American Pediatric Assoc. Guidelines):

The Plan pays: 100% of contracted rate
 The covered person pays: 0% of contracted rate

After deductible

80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

BENEFIT SUMMARY

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

The Plan pays: 100% of contracted rate
The covered person pays: 0% of contracted rate

After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Psychiatric Benefits

Inpatient
(Limited to 60 days per calendar year including partial hospitalization with the total benefit not to exceed \$450 per day)

After Deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

The Plan pays: 100% of contracted rate minus co-pay
The covered person pays: \$100 co-pay
and any remaining balance

Outpatient
(Benefit limited to a 30 visit calendar year maximum with the total benefit not to exceed \$100 per visit)

After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

The Plan pays: 100% of contracted rate minus co-pay
The covered person pays: \$10 co-pay
and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
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Second Surgical Opinion (Not mandatory, at patient's prerogative)

The Plan pays 100% of contracted rate minus co-pay
The covered person pays: \$10 co-pay

After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Skilled Nursing Facility Care
(Admission must be within 14 days of a prior hospital stay.)
(Benefit is limited to 365 days per calendar year)

The Plan pays: 100% of contracted rate minus co-pay
The covered person pays: \$100 co-pay

After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

Surgery: Physician's Charge (Inpatient and Outpatient)

The Plan Pays: 100% of contracted rate
The covered person pays: 0% of contracted rate

After deductible
80% of UCR Amount
20% of UCR Amount
and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
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Therapy including (but not limited to):

Cardiac	Respiratory	Chemo
Oxygen	Diabetes - limited to state mandated benefit	

Above services are all subject to the following:

The Plan Pays: 100% of contracted rate
 The covered person pays: 0% of contracted rate

Therapy (Physical): (Benefit limited to 32 Visits)

Inpatient

The Plan Pays: 100% of contracted rate
 The covered person pays: 0% of contracted rate

After deductible
 80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

Outpatient

The Plan Pays: 100% of contracted rate minus co-pay
 The covered person pays: \$10 co-pay

After deductible
 80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

BENEFIT SUMMARY

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
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Urgent Care Center

The Plan Pays: 100% of contracted rate minus co-pay
 The covered person pays: \$10 co-pay (Waived if admitted)

After deductible
 80% of UCR Amount
 20% of UCR Amount
 and any remaining balance

Exclusions:

see the section entitled **WHAT THE MEDICAL PLAN DOES NOT COVER** (Pages 59-65) in this Summary Plan Description for further details.

Deductible: Individual: \$ 0
 Family: \$ 0

\$ 200
 \$ 600

Out-Of-Pocket Maximum:

Individual: N/A
 Family: N/A

\$ 800 plus deductible
 \$ 2,400 plus deductible

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

Lifetime Individual Maximum Benefit in-network and out-of-network combined: Unlimited
Calendar Year Individual Maximum Benefit in-network and out-of-network combined: \$1,000,000

WHAT THE MEDICAL PLAN COVERS

Please Note: The phrase “the Plan pays the allowable amount” refers to the medically necessary covered services and supplies that are eligible for benefits, subject to the benefits, limitations, and exclusions outlined throughout this Summary Plan Description. For in-network services, the allowable amount is the contracted rate less any co-payments. For out-of-network services, the allowable amount is the UCR Amount less any deductibles and coinsurance. The cost sharing component between the Plan and the covered person is defined in the section entitled BENEFIT SUMMARY (Pages 17-33) of this Summary Plan Description.

Allergy Treatment

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

Ambulance Transportation

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

Ambulatory Services and Supplies

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

Tests ordered by the surgeon before surgery if:

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

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

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

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

Limitations and/or Exceptions

No benefit is paid for charges incurred:

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

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

Ambulatory Surgery Benefit

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

It is not expected to:

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

Ancillary Services

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

Anesthesia Benefit

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

Assistant Surgeon Benefit

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

Bereavement Benefits

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

Blood and Blood Plasma (Including Blood Transfusions)

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

Cardiac Rehabilitation Services (Therapy)

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

Chemical Dependence - Inpatient

The plan pays the allowable amount for the treatment of chemical dependence (including detoxification) up to a maximum benefit not to exceed \$450 per day regardless of whether the facility is considered in-network or out-of-network. Coverage is limited to 30 days per admission and to two admissions per calendar year, including partial hospitalization. If covered medical expenses are incurred for partial hospitalization because of a chemical dependence disorder, payment will be made on the same basis as if the covered person was confined in a hospital. Such care will be credited toward the inpatient maximum on the basis of two days of partial hospitalization being equal to one day of inpatient confinement.

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

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

Detox is limited to 7 days maximum per confinement.

Chemical Dependence - Outpatient

The Plan pays the allowable amount for medically necessary outpatient treatment of chemical dependence. This benefit will not exceed \$100 per visit regardless of whether the provider is considered in-network or out-of-network. Benefits will be provided for up to 60 outpatient visits in each calendar year for each covered person for the diagnosis or treatment of chemical dependence. Up to 20 of the 60 visits may be used for family therapy, provided:

The person in need of treatment is a covered person;

The family members receiving therapy are covered persons; and

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

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

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

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

Chemotherapy

The Plan pays the allowable amount for the medically necessary services and medications used for non-experimental treatment of malignant disease by chemical or biological anti-neoplastic agents.

Chiropractic or Manual Manipulation Care

The Plan pays the allowable amount for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Benefits will be provided for up to 20 visits in each calendar year provided the care must be medically necessary and not custodial in nature or for maintenance treatment, and must be within the scope of licensure of the health care professional.

Consultation Expense Benefit

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

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

Dental Services

The Plan pays the allowable amount for medically necessary dental services rendered by a physician, dentist, or oral surgeon for the treatment of a congenital disease or anomaly; or of an injury to sound, natural teeth incurred as a result of an accident sustained while the individual is/was covered by the Plan. In the case of injury, care must commence within six (6) months following the date of the accident.

Diabetic Equipment and Supplies

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

- Blood glucose monitors and control solutions;**
- Blood glucose monitors for the legally blind;**
- Testing products for glucose monitors, visual reading, and urine testing;**
- Injection aids;**
- Lancing devices;**
- Cartridges for the legally blind;**

- Syringes;**
- Alcohol swabs;**
- Data management systems;**
- Insulin pumps and appurtenances thereto;**
- Insulin infusion devices; and**
- Insulin and oral agents for controlling blood sugar.**

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

Diabetes Education

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

A covered person is initially diagnosed with diabetes;

A Physician diagnoses a significant change in the diabetic symptoms or condition that requires changes in self-management; or

It is determined that reeducation or refresher education is necessary.

The self-management education must be provided by:

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

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

A professional provider described above during a visit to a patient's

home. Benefits will only be provided for such education in the home when it is determined that it is medically necessary.

Dialysis

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

Diagnostic X-Ray and Laboratory (Outpatient)

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

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

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

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

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

Diagnostic X-Ray and Laboratory (Professional Provider)

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

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

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

Diagnostic Machine Tests. No additional co-payment is required for

the reading and interpretation of diagnostic services of this type (if recognized as a separate service).

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

Durable Medical Equipment

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

Examples of such durable medical equipment are respirators, canes, crutches, walkers, and wheelchairs. Such equipment does not include, for example, air conditioners, dehumidifiers, physical fitness equipment, hearing aids, eyeglasses & contact lenses, or articles of clothing (including shoes), regardless of medical necessity. In addition, the Plan will not cover any changes to home, automobile, or personal property.

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

Emergency Services

The Plan pays the medically necessary allowable amount for those covered services, supplies and facility related expenses that are provided by the hospital for emergency care given for an emergency condition. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough

that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

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

The person's bodily functions could be seriously impaired;

One of the organs or other parts of the body could be seriously harmed;
or

The person could be seriously disfigured.

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

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

The Plan will also pay for services provided in an emergency room that are not considered emergency care for an emergency condition. A co-payment will apply to these services.

Gynecology (Routine)

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

Home Health Care Services

The Plan pays the allowable amount for certain medical services provided in the home by a home health care agency. Each visit by a home health care team is counted as one visit. Each period of up to four (4) hours of home health aide will be considered one visit. The maximum benefit for home health care is limited to 60 visits per calendar year.

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

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

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

It is determined that home health care is medically necessary.

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

Part time or intermittent home nursing care by or under the supervision of a registered professional nurse;

Part time or intermittent home health aide services which consist primarily of caring for the covered person;

Physical, occupational or respiratory therapy which is provided by the home health care agency;

Nutritional counseling; and

Medical supplies (including medicines) and laboratory services which are prescribed by the physician.

The above benefits will be covered when:

They are ordered by the physician; and

They are furnished in the patient's home.

Hospice Care

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

The covered person experiences an illness for which the attending physician's prognosis for life expectancy is estimated to be six months

or less;

Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate;

The attending physician refers the covered person to the hospice care program and is in agreement with the plan for care of the condition;

It is determined that hospice care is medically necessary; and

The covered person is formally admitted to the hospice program.

Covered Benefits Include Only the Following:

The confinement of a terminally ill patient as an inpatient in a hospice facility is covered; and

The hospice care furnished to the terminally ill patient, by the hospice provider, in the patient's home is covered.

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

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

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

The maximum lifetime benefit for hospice care is 210 days.

Hospital Benefits

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

A registered bed patient;

Required to stay in a hospital for acute care that is determined to be medically necessary; and

Not admitted to the hospital for mental, nervous, or emotional disorders, or chemical dependence including detoxification - except as defined under the inpatient psychiatric or the inpatient chemical

dependence benefit.

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

Room, board and general nursing services including ICU room and board charges, and all regular daily services, are paid up to the hospital's average semi-private room rate. If a physician certifies that a private room is a medical necessity for the purposes of isolation, charges will be covered at the hospital's average rate for a private room. If the facility has no such rooms, the Plan Administrator will use the rate most commonly charged by similar institutions in the same geographic area.

Hospital services and supplies, including patient meals, special diets, medicines, laboratory tests, use of operating rooms and special equipment, anesthetics and x-rays.

Mastectomy care consisting of an inpatient hospital stay following lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer. The medically appropriate length of stay will be determined by the attending physician, in consultation with the patient.

The charges are paid for a hospital's emergency room treatment of a sickness or injury.

The charges are paid for hospital services connected with outpatient surgery, including use of treatment rooms, x-rays, laboratory tests, surgical dressings and medicines.

The charges are paid for blood and blood plasma (not replaced on behalf of patient).

Important Note: The Plan does not cover room and board charges for weekend hospital admissions (Fridays or Saturdays) when treatment is not scheduled to begin until Monday. However, benefits will be payable if hospitalization and medically necessary treatments begin on these days. Benefits are available for an unlimited number of inpatient hospital days of care, starting with the date of admission.

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

Inpatient Physician Services

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

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

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

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

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

Mammography

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

Maternity Care

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

Medical Supplies

The Plan pays the allowable amount for medically necessary medical supplies when a covered person is not an inpatient. Benefits for medical supplies include IV therapy, ostomy bags and supplies required for their use; catheters; and dressings, when it is determined that a large quantity is necessary for the

treatment of conditions such as cancer, diabetic ulcers, and burns. A physician must order the use of these supplies.

Newborn Care

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

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

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

Oral Surgery

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

Organ/Tissue Transplants

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

Organ or tissue procurement from a cadaver which consists of removing, preserving, and transporting the donated part;

Services and supplies furnished by a hospital;

Drug therapy to prevent rejection of the transplanted organ or tissue; and

Surgical storage and transportation costs directly related to the

procurement of an organ or tissue used in a transplant will be covered for each such procedure completed.

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

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

Organs must have been from human donors, no other animal or artificial organs will be approved; and

Recipient must be in otherwise good general health and have a high probability of surviving the procedure.

Orthotic Devices

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

Oxygen

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

Physical Therapy

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

Podiatry

The Plan pays the allowable amount for medically necessary services of a licensed podiatrist except for routine care of the feet.

Pre-Surgical Testing

The Plan pays the allowable amount for medically necessary pre-surgery testing ordered by a surgeon which are performed within 7 days prior to admission, if:

Proper diagnosis and treatment require the tests;

Surgery has been scheduled and an operating room has been reserved before the tests are given;

The tests are performed at an ambulatory surgical center or hospital; and

The tests are billed by, and payable to an ambulatory surgical center or hospital.

Prescription Drugs

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

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

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

Prescription Drugs used for the purpose of smoking cessation are covered under the Plan subject to the prior authorization of their use. A course of treatment is available once a lifetime for covered enrollees and shall not exceed a 180 day supply of the prescription drug.

A prescription drug card will be issued to all covered persons. This card should be presented to the pharmacy at the time a prescription drug is purchased. If you do not use your prescription drug card, or go to a pharmacy outside of the

network, then you must pay for your prescription and then file a claim with the prescription Plan Administrator. Any co-payments that are paid under the prescription drug program are not eligible to be considered for reimbursement under any other portion of the Plan.

The prescription drug benefits provided by the Plan are summarized as follows:

Retail Pharmacy (30 day supply):

The covered person pays: \$ 5 per generic prescription

The covered person pays: \$ 10 per brand name prescription if no
Generic is available

The covered person pays: \$ 15 per brand name prescription if Generic
is available

Mail-Order Pharmacy – Maintenance Medications Only (90 day supply):

The covered person pays: \$ 2 per generic prescription

The covered person pays: \$ 5 per brand name prescription

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

If a pharmacy dispenses a generic drug, the covered person will pay the generic drug co-payment noted above.

If the pharmacy dispenses a brand name drug and there is a generic drug which can be substituted, but is not, then the covered person pays the \$15 brand name co-payment as noted above.

If no “A” rated generic drug is available for substitution in place of a brand name drug, the covered person pays the \$10 brand name co-payment as noted above.

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

Necessary for the care and treatment of an illness;

Prescribed in writing by an authorized physician;

Reasonable and customary; and

Not listed in the Exclusion Section, below.

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

Mail Order Program

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

How to use the program:

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

Complete an enrollment/order form, and for new participants, complete the confidential patient profile. This form will need to be completed with the first order only. In the future, only additional information or changes to your medical condition need to be reported. Please notify the mail order administrator in writing.

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

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

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

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

Prescription Benefits After Termination of Coverage

If you are totally disabled from an illness, injury, or pregnancy on the date of termination of your coverage, the Plan benefits are available while you are still totally disabled from that illness, injury, or pregnancy within a period of one year after termination of your coverage.

Prescription Drug Exclusions:

The following exclusions apply to the prescription drug benefit:

Non-legend drugs, other than injectable insulin.

The charges for the administration or injection of any drug.

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

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

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

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

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

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

Immunization agents, biological sera, blood or blood plasma.

More than a 90 day supply when dispensed in any one prescription order.

Any contraceptive device is excluded from coverage under this Plan.

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

Cosmetic Drugs (e.g. Minoxidil (Rogaine), Renova, Retin-A).

Growth Hormones

Infertility Medications.

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

Prescription Drug Plan Miscellaneous Provisions

No benefits, claims, or money due, or due to become due, from the Plan under the prescription drug program are assignable by you or your dependents, and any such assignment shall be null and void.

No action at law or inequity shall be brought to recover from the Plan prior to the expiration of 60 days after proof of claim, on the appropriate form provided by the Plan, has been filed in accordance with the requirements hereof. No such action shall be brought unless brought within two years from the expiration of the time within which proof of claim is required.

The Plan shall not be liable for any claims or injury arising out of or in connection with the sale, dispensing or manufacturing of any drug obtained under this program.

The Plan may deny benefits for any drug prescribed or dispensed in a manner that the Plan deems to be contrary to normal medical practice.

There is no conversion privilege for the drug benefits provided under this program.

The pharmacy is not required to dispense any drug which in the pharmacist's professional judgement should not be dispensed.

Preventive Care

The Plan pays the allowable amount for one routine physical examination each calendar year for each covered person age 19 and older. The examination need

not be medically necessary nor required because of specific symptoms or diagnosis.

Professional Provider Office Visit

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

Prosthetic Devices

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

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

Psychiatric Treatment - Inpatient

The Plan pays the allowable amount for the medically necessary diagnosis and treatment of mental, nervous, or emotional disorders rendered in a hospital or psychiatric hospital up to a maximum benefit not to exceed \$450 per day regardless of whether the facility is considered in-network or out-of-network up to 60 days in a calendar year. If covered medical expenses are incurred for partial hospitalization because of a psychiatric disorder, payment will be made on the same basis as if the covered person was confined in a hospital. Partial hospitalization is treatment in a hospital or other licensed facility for less than 24 hours but more than four hours in any one day. Such care will be credited toward the inpatient maximum on the basis of two days of partial hospitalization being equal to one day of inpatient confinement. Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature. To be eligible for inpatient psychiatric care services, a covered person must be a registered inpatient and the inpatient stay must be determined to be medically necessary.

Psychiatric Treatment - Outpatient

The Plan pays the allowable amount for medically necessary professional provider services for the outpatient diagnosis and treatment of a mental, nervous, or emotional disorder. This benefit will not exceed \$100 per visit regardless of whether the provider is considered in-network or out-of-network with a calendar year limitation of 30 visits.

Outpatient mental illness treatment expenses include the following services when rendered by licensed physicians, psychiatrists, psychologists, psychotherapists, or certified social workers (CSW):

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

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

Radiation Therapy

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

Reconstructive or Corrective Surgery

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

- To correct an abnormal congenital condition in a child,
- To repair or alleviate damage which occurred as the result of an accident,
- To repair an injury which occurs while the person is covered under this Plan, or
- To comply with the Women's Health and Cancer Rights Act of 1998. Services include reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of

physical complications of all stages of mastectomy, including lymphedemas in a manner determined by the attending physician and the patient to be appropriate.

Respiratory Therapy

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

Second Medical Opinion (Cancer-Related)

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

Second Surgical Opinion

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

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

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

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

Skilled Nursing Facility

The Plan pays the allowable amount for services provided by a skilled nursing facility while a covered person is recovering from an illness or injury for the same or related causes. Benefits include room and board charges and other necessary services and supplies (except physician's fees and personal items) furnished while the patient is under continuous care of his/her physician, and requires 24-hour nursing care. Benefits will not exceed the standard semi-private rate in the hospital from which the patient was transferred. This benefit is limited to 365 days per calendar year maximum. The admission must be within 14 days of a prior hospital stay.

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

A registered bed patient in a skilled nursing facility; and

The stay in the skilled nursing facility is for skilled care or treatment that is medically necessary; and

The patient would otherwise require skilled care as a hospital inpatient if they were not in the skilled nursing facility.

Inpatient skilled nursing facility covered services include the following:

Nursing care given or supervised by a registered nurse;

Bed and board in a semi-private room;

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

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

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

Sterilization

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

Surgical Services Benefit

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

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

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

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

Urgent Care Center

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

Well Child Visits

The plan pays the allowable amount for periodic, well child visits to detect possible medical problems up to the child's 19th birthday. Medically necessary visits to a professional provider to diagnose or treat a symptom or injury are not covered under this benefit. The covered services for well child visits provided under this benefit shall be in accordance with the prevailing clinical standards of the American Academy of Pediatrics, including an initial hospital check-up and necessary immunizations, as determined by the superintendent of insurance, in consultation with the commissioner of health, of the State of New York, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenza type b and hepatitis b.

The Plan will cover services typically provided in conjunction with a well child visit. Such services include at least: complete medical histories; a complete physical exam; developmental assessments; anticipatory guidance; laboratory tests performed in the practitioner's office or in a clinical laboratory; and/or other services ordered at the time of the well child visit.

X-Ray and Radium Therapy

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

WHAT THE MEDICAL PLAN DOES NOT COVER

General Exclusions

1. Any expense for services not directly related to, or medically necessary for, the diagnosis or treatment of an illness or injury, unless specified in the Benefit Summary Section and the What The Medical Plan Covers Section.
2. Any services if the covered person was an inpatient in any institutional provider, or receiving home care or hospice benefits, on the day coverage begins under the Plan. However, after the discharge from the facility or program, benefit payments for future covered services will be provided.
3. Any services or care that is eligible for coverage by mandatory no-fault automobile insurance until the covered person has used up all the benefits under the mandatory no-fault policy. If a claim for no-fault benefits is denied, the covered person must file for an arbitration hearing if the Plan Administrator requests such. This exclusion applies even if the covered person does not make a proper or timely claim for benefits available under the no-fault policy. Should the no-fault policy have a deductible, benefit payment will be made for covered services up to the amount of the deductible.
4. No benefit payment will be made for any service or care for which benefits are payable under Medicare; or for which benefits are paid under any other federal, state or local government program; except when required by state or federal law. When a covered person is eligible for a government program other than Medicare that is subject to this exclusion, benefits will be reduced by the amount the government program paid for the services. When a covered person is eligible for Medicare, benefits will be reduced by the amount Medicare would have paid for the services. This reduction is made even if:

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

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

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

1. The employee is in “current employment status” (working actively and not retired) with the County; and
2. The County is required by law to have this Plan pay its benefits before Medicare.

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

1. The employee is in “current employment status” (working actively and not retired) with the County; and
2. This Plan is a large group health plan, as defined by law, and the County is, therefore, required by law to have this Plan pay its benefits before Medicare pays.

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

5. Any expense incurred while on full-time active duty in the armed forces of any country, combination of countries, or international authority.
6. Any expense incurred in connection with any accidental bodily injury or illness arising out of, or in the course of any employment (past or present), and which is compensatory under any Workers’ Compensation or Occupational Disease Act or Law.
7. Services received in a public health service hospital, or any facility operated by the U.S. government or any of its agencies are not covered, unless the benefit payment will be made for only service or care for non-service related conditions.

8. Inpatient hospital care received by retirees or dependents described in SS.1074(b), 1076(a), or 1076(b) of Title 10, United States Code is not covered. These codes state that a retiree and/or a dependent of a retiree who was in a uniformed service may be given medical and dental care in any facility of any uniformed service, subject to availability of space and capabilities of the staff. Therefore, if care is received at a facility of any uniformed service, this Plan will not duplicate benefits.
9. Dental Services: The Plan does not cover any dental services unless specified in the Benefit Summary Section and the What The Medical Plan Covers Section.
10. Optical Services: The Plan does not cover charges for exams to determine the need for (or change of) eyeglasses or lenses of any type except for the medically necessary initial replacements for loss of the natural lens(es). The Plan does not cover charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses. This exclusions shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery. The Plan does not cover charges for eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring), orthoptics, visual therapy, or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity.
11. Any expense for services rendered by the covered person or the covered person's immediate family members.
12. Any expense which exceeds the UCR Amount. See Page 15.
13. Any expense for care, services, and supplies not prescribed by a licensed health provider and/or treatment not rendered by a licensed health provider.
14. Any routine or elective expenses not mandated by state law except as deemed medically necessary by the Plan Administrator.
15. Custodial care.
16. Any service or care for outpatient occupational or speech therapy, except when provided as part of the home health care services benefit of the Plan.
17. Expenses applied toward satisfaction of the deductible.

18. No payment will be made by the Plan for any expenses for services in connection with elective cosmetic surgery that is primarily intended to improve the covered person's appearance. Such services include, but are not limited to, breast reduction or enlargement, rhinoplasty, and hair transplants. The Plan will, however, pay for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Plan will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under the Plan that has resulted in a functional defect. The Plan will also provide coverage for services in connection with reconstructive surgery following a mastectomy as specified in the Benefit Summary and the What The Medical Plan Covers Sections.
19. Blood or blood plasma that is replaced by or for the patient.
20. Expenses for a standby physician.
21. Any service or care related to conception by artificial means, including, but not limited to, fertility drugs, in vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cryopreservation of sperm or embryos, intra cytoplasmic sperm injection, surrogate parenting (except that benefits will be provided for covered services rendered to a surrogate parenting (except that benefits will be provided for covered services rendered to a surrogate parent who is covered under this Plan), or other techniques or methods of assisted reproductive technology that may be developed, the intended outcome of which is similar to these procedures, unless otherwise required by law. This exclusion applies but is not limited to the following services: routine examinations, laboratory tests, birth control counseling, genetic counseling, and diagnostic testing for the sole purpose of inducing pregnancy.
22. Proper adjustment of, or purchase of a hearing aid.
23. Any expense for career or pastoral counseling.
24. Services or supplies of an educational, experimental or investigatory nature.

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

disabilities.

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

This includes, but is not limited to:

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

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

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

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

25. Charges for unnecessary services or supplies. A charge for services or supplies, including tests and check-up exams to the extent that they are not needed for the diagnosis of a sickness or injury, or the medical care of a diagnosed sickness or injury, unless specified in the Benefit Summary Section under Preventive Care.
26. Charges for the reversal of any sterilization procedure.
27. Expenses for sex transformation including but not limited to hormones and any psychiatric treatment related to the transformation.
28. Charges for orthoptic therapy (vision exercises).

29. Services for weight reduction programs.
30. Any services related to terminal illness that have been or should be included in the payment to a Hospice Program. Bereavement counseling services, except as provided under the Hospice Benefit Provisions.
31. Hypnosis.
32. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
33. Lamaze (type) Classes - child bearing classes.
34. Mail and/or shipping and handling expenses.
35. Travel expenses of a health provider or a covered person.
36. Sale(s) tax.
37. Adoption expenses.
38. Services or care that is furnished without charge, or that would have been furnished without charge if the recipient was not covered under the provisions of this Plan.
39. Any service or care when it is determined that the service or care is not expected to improve the condition of the recipient. This exclusion is independent of the hospice care benefit.
40. Any pharmacy services, clinical laboratory, x-ray or imaging services that were provided pursuant to a referral prohibited by New York State Public Health Law.
41. Services of a private duty registered nurse or licensed practical nurse furnished in a hospital, even if ordered by a health professional, except if the attending physician certifies in writing that a certified registered nurse was not available provided in any case that such nurse is one who does not ordinarily reside in the home of the covered person and is not a member of the covered person’s family.
42. No benefit payment will be made for the elective termination of a pregnancy, including abortion, and related expenses incurred therefore.

43. Charges incurred prior to the effective date of coverage under the Plan or after the coverage is terminated, unless The Extension of Benefits Provision applies.
44. Charges incurred outside the United States if the covered person traveled to such location for the sole purpose of obtaining medical services, drugs or supplies, except Canada. Please note that the County's Provider Network does not include any Canadian providers so that any expenses incurred in Canada will be classified as out-of-network services and will result in out-of-pocket expenses. Additionally, note that since prescription drugs that are purchased in Canada and brought back into the United States are technically not FDA approved drugs, they are excluded from coverage under this plan.

DEFINITIONS

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

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

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

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

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

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

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

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

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

operative report, and a discharge summary.

It provides a physician trained in cardiopulmonary resuscitation.

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

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

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

Makes charges.

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

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

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

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

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

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

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

Accepts only patients with low risk pregnancies.

Has a written agreement with a hospital in the area for emergency transfer of a patient or child. Written procedures for such a transfer

must be displayed, and the staff must be aware of them.

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

Keeps a medical record on each patient and child.

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

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

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

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

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

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

It is a public facility that provides services, especially for detoxification or rehabilitation, and it is licensed to provide those services in the state in which the facility is located.

It is a comprehensive health service organization, or community mental health clinic, that furnishes mental health services with the approval of the appropriate governmental authority; or it is any public facility, or portion thereof, that provides services especially for rehabilitation. It must be licensed for these purposes.

It is a licensed or accredited hospital, or a facility that is affiliated with a hospital under a contractual agreement.

A Chemical Dependence Treatment Facility must also:

Have an established patient referral system; and

Be accredited as such a facility by the Joint Commission on Accreditation of HealthCare Organizations.

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

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

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

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

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

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

Overseen by a physician and operates under the supervision of a physician or a registered graduate nurse. Full-time supervision means a physician or registered graduate nurse is regularly on the premises at least 40 hours per week.

Maintains a daily medical record for each patient.

Has a written agreement or arrangement with a physician to provide emergency care for its patients.

Qualifies as an "Extended Care Facility" under the health insurance provided by Title XVIII of the Social Security Act, as amended.

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

In no event, however, will a convalescent hospital be deemed to include an

institution which is, other than incidentally, a place of rest, a place for the aged, the chemically dependent, the blind or deaf, the mentally ill or retarded, or a place of custodial care.

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

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

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

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

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

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

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

Disability The complete inability of the employee to perform any and all the usual duties of his or her daily living.

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

Medically necessary;

Not primarily and customarily used for non-medical purposes;

Designed for prolonged use; and

Designed for a specific therapeutic purpose in the treatment of an illness or injury.

Emergency Services, Emergency Condition Emergency Services are medical, surgical, hospital, and related health care services and testing, required

to treat an emergency condition. An emergency condition is an injury or the sudden onset of a medical or behavioral condition. The symptoms of the emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

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

The person's bodily functions could be seriously impaired or the person could be seriously disfigured;

One of the organs or other parts of the body could be seriously harmed.

Employer St. Lawrence County.

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

This includes, but is not limited to:

All phases of clinical trials;

All treatment protocols based upon or similar to those used in clinical trials;

Drugs approved by the Federal Food and Drug Administration under its Treatment Investigatory New Drug Regulation; or

Federally approved drugs used for unrecognized treatment indications.

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

Extended Care Facility Any one of the following:

A facility owned and operated by a hospital, or under written contract with a hospital.

A distinct part of a hospital.

A facility, or distinct part of a facility, that meets the requirements for approved operation under Medicare.

All the following must be true. The facility must:

Be operated according to the laws of the state or locality in which it is located. This includes the necessary licensing.

Be primarily engaged in providing care for persons recovering from sickness or injury.

Be under the supervision of a physician or staff of physicians on call at all times.

It must provide all the following:

Room and board.

Skilled 24 hours per day inpatient nursing services; a full-time R.N. or other nursing staff under the supervision of a physician or R.N. on duty at least eight (8) hours per day.

Adequate daily medical records for each patient.

Necessary and customary special services.

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

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

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

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

Home Health Care Agency A nonprofit public home health care service or agency possessing a valid certificate or approval issued in accordance with Title

XVIII of the Social Security Act, or licensed and approved by the State.

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

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

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

The program must meet standards set by the National Hospice Organization and approved by the Plan Administrator. If such a program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.

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

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

- A social worker;
- A clergyman/counselor;
- Volunteers;
- A clinical psychologist;
- A physiotherapist; or an occupational therapist

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

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

It must have organized departments of medicine and surgery;

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

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

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

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

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

A Hospital must also:

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

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

Ensure that each specialized program provided by it must:

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

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

attending physician.

A Hospital must also:

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

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

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

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

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

Is operated primarily as a school.

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

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

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

Injury Bodily harm which results from an accident, occurring directly and independently of all other causes, and which results in loss covered by the Plan.

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

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

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

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

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

Necessary to meet a patient’s basic health needs;

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

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

The most appropriate method of providing safe and adequate care.

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

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

A benefit payment will not be made if the Plan Administrator determines that the service, care, or supply was not medically necessary. However, the Plan will pay benefits if directed to do so pursuant to external appeal. The fact that any particular physician or health care professional may prescribe, order, recommend, or approve service, supply or technology does not, in itself, make the services medically necessary.

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

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

Mental Illness A mental or nervous disorder such as neurosis, psychoneurosis, psychosis, and other mental and emotional diseases and disorders. Mental or nervous disorders will be classified as such by the International Classification of Diseases Manual.

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

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

Nurse A registered nurse or licensed practical nurse other than the employee or a member of his or her family.

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

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

Outpatient Mental Health Treatment Facility A comprehensive health service organization, a licensed or accredited hospital, or community mental health center, or other mental health clinic which furnishes mental health services with the approval of the appropriate governmental authority, any public facility or portion thereof which provides services especially for the diagnosis, evaluation, service, or treatment of mental illness or emotional disorder.

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

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

Plan The St Lawrence County Healthcare Plan.

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

Plan Anniversary Date The date occurring in each calendar year which is an anniversary of the effective date of this plan, January 1, 2002.

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

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

Primary Attending Physician This is the physician who is treating the terminally-ill person, and recommends admittance to a Hospice Care Program.

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

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

Must be licensed to give medical treatment;

Is operated under the supervision of a physician;

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

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

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

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

Respiratory Therapy The treatment to preserve or improve pulmonary function.

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

Sickness Any physical illness, mental illness, or pregnancy.

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

Is operated in accordance with the applicable laws in the jurisdiction in which it is located;

Provides inpatient care and physical restoration services to those convalescing from illness or injury and helps them to meet a goal of self-care in daily living activities;

Overseen by a physician and operates under the supervision of a licensed physician, or registered graduate nurse (R. N.) who is devoting full time to such supervision;

Is regularly engaged in providing room and board, and continuously provides twenty-four (24) hour per day skilled nursing care by licensed nurses directed by a full-time registered graduate nurse (R.N.);

Maintains a complete medical record of each covered person who is under the care of a duly licensed physician;

Has a utilization review plan; and

Is not, other than incidentally, a rest home, a home for the aged, a place for custodial care or educational care, or a home for the chemically dependent, the mentally retarded or mentally ill.

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

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

Supervising Doctor The physician directing the Hospice Care Program.

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

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

TMJ The abbreviation for temporomandibular joint syndrome.

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

Written, in writing Signed, dated, and received at Plan Administrator in a form acceptable to the Plan Administrator.

GENERAL PROVISIONS

Submitting a Claim

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

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

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

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

How to File a Claim

The Plan will initially provide you with pre-addressed claim envelopes and your own GROUP IDENTIFICATION CARD. Subsequent claim envelopes may be obtained from your employer. A new claim cannot be processed without a FULLY completed claim envelope. Follow the instructions on the form itself, and make sure you answer all questions. Unanswered questions will delay consideration of your claim.

It is important that the doctor or hospital state the REASON FOR TREATMENT and/or Diagnosis on the bill. All bills must be itemized. In most cases the doctor will bill his patient for services rendered. If you have a claim envelope, give it to the doctor's office and ask that they send the bill directly to our office. A claim envelope must accompany the submission of all bills. If the doctor insists on being paid by you, then forward the receipted bill to our office

along with a completed claim envelope.

Claim Confidentiality

The nature of all claims will remain a confidential matter between the Plan Member and HHS Administrators.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of the coordination of benefits provision of this Plan or any other provision of similar purpose of any other plan, the Plan Supervisor may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization or person any information, with respect to any person, which the Plan Supervisor deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Supervisor such information as may be necessary to implement the provision.

Choice of Provider

The covered person has free choice of any provider.

Assignment

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

Exam

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

Legal Action

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

Loss of Benefits

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

APPEALING A CLAIM

Claims Other Than Medical Necessity or Experimental/Investigational Services

This section describes the appeal process that applies to a claim denied, in whole or in part. If a claim is denied in whole or in part, the covered person will receive notification of a claim denial via an Explanation Of Benefits (EOB) Form. The EOB Form will be provided by the Plan Administrator. The EOB will show the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for the consideration of the claim, the Plan Administrator will request it.

If a covered person does not agree with the denial of a claim, the covered person may submit a written request for the Plan Supervisor to review the claim in question and give a written decision on the review within 60 days after such a request is received.

Claim Review Procedure

If your claim should be denied in whole or in part, you will receive written notification delivered in the same fashion as reimbursement of a claim. A claim worksheet will be provided by the Third Party Administrator showing the calculation of the total amount payable, and the reason; if you do not understand the reason for any reimbursed amount, call the Third Party Administrator. Upon written request of the covered person, the Plan Supervisor will review the claim in question and give a written decision on the review within 60 days after such request is received.

This benefit plan contains a provision coordinating it with other benefit plans under which an individual is covered. When a claim is made, the primary plan pays its benefits without regard to any other plan.

The secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, on a per claim basis, which were incurred by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses. Under no circumstances will the Plan pay more than it would without the coordination provision.

The UCR Expense is any necessary, reasonable and customary expense covered, at least in part, by one of the plans of the same type (medical). If a person covered by the Plan has expenses for a stay in a hospital's private room, the term UCR Expense will not include the difference between the charge for the private room and the portion of that charge on which the benefits of the Plan are based, unless:

- The private room charge is a covered expense under one of the plans,
- or
- The person's stay in a private room is medically necessary in terms of generally accepted medical practice.

For the purpose of this section only, the term plan will include:

- Any group insurance and group or group remittance subscriber contracts;
- Any uninsured arrangements of group coverage (including this Plan);
- Any group coverage through health maintenance organizations (HMOs), and other prepayment, group practice and individual practice plans;
- Any blanket contract, except blanket school accident coverage or such coverage issued to a substantially similar group, as defined by New York State Insurance Department Regulation, where the policyholder pays the premium;
- Medicare or other government program, except a state program under Medicaid and except a law or plan when, by law, its benefits are in excess to those of any private insurance plan or other non-governmental plan;
- Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional mandatory automobile "fault"

type contracts.

Plan does not include any individual or family policies or contracts or public medical assistance programs.

First party auto insurance coverage is considered primary. The Plan coordinates the benefits payable under the Plan with the first party benefits that auto insurance pays or would pay without regard to fault for the same covered expenses. This also applies to the extent first party auto insurance coverage is legally required but not in force and the covered employee and/or dependent was responsible for maintaining such coverage.

The term UCR Expense as used in this provision means any reasonable and customary charges for necessary medical or care or treatment for which at least a portion is covered under one or more of the plans covering the person with respect to whom a claim is made.

A plan without a similar coordination provision is always the primary plan. When the other plans involved have such a provision, the following rules apply:

The plan covering the patient directly, rather than as an employee's dependent, is primary and the other is secondary (plan benefits will only be coordinated with similar benefits provided under the other plan(s) for which a claim may be made).

If a child is covered under both parents' plans, the plan of the parent whose birthday (month and day in the calendar year, not the birth year) falls earlier in the year will be determined to be the primary plan over the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan which was the longer in effect will be determined to be the primary plan over the parent whose plan was in effect for the shorter time. If the other plan does not have the birthday rule described herein, but instead has a rule based upon the gender of the parent, and if as a result the plans do not agree on the order benefits, the rule of the other plan will determine the order of benefits.

However, in the case of a person for whom a claim is made as a dependent child:

a) when the parents are divorced and the parent granted custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined to be primary before the benefits of a plan which covers the child as a dependent of the parent without custody; or

b) when the parents are divorced and the parent granted custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined to be primary before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined to be primary before the benefits of a plan which covers that child as a dependent of the parent without custody.

c) if the specific terms of a court decree say that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of that parent's plan has actual knowledge of those terms, then the benefits of that plan will always be determined first. But this paragraph will not apply when any benefits are actually paid or provided before the entity has that knowledge.

The benefits of a plan (the primary plan) covering a person as an employee who is neither laid off nor retired, or as that employee's dependent, will be determined before those of a plan (the secondary plan) which covers that person as a laid off or retired employee, or as that employee's dependent. However, this rule applies only if both plans have it. Otherwise, this rule is ignored.

If none of the previous rules apply, the plan covering the person longer is the primary plan.

When this program is the secondary plan, and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase the benefit.

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

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

For the purpose of coordination of benefits, the Plan Administrator or its agent:

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

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

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

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

MEDICARE ELIGIBLE EMPLOYEE COVERAGE

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

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

Is an active employee age 65 or more;

Is a dependent spouse age 65 or more of an active employee; or

Has decided to retain this Plan as his/her primary coverage (see note below), the modification described later on this page will not operate. Instead, Medicare will adjust its benefits, as required by law, to take into account benefits payable under this Plan.

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

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

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

SITUATIONS AFFECTING PLAN BENEFITS

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

Termination of Employment

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

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

Personal Leave of Absence

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

Medical Leave of Absence

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

Family Medical Leave Act

This Federal Law was enacted in 1993. Employees who are eligible for leave under this act can continue their health insurance at the same rate as active employees provided they meet the premium requirements.

Converting Medical Coverage

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

Attachment of Benefits

To the extent permitted by law, all rights and benefits under this Plan are

exempt from execution, attachment, garnishment, or other legal process for the covered person's debts or liabilities.

Discrimination Tests

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

CONTINUATION OF COVERAGE

Continuation of Coverage under COBRA

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

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

A covered person who is a County Employee has the right to choose continuation coverage if coverage under the Plan terminates because of a reduction in hours of employment or because employment has terminated (for reasons other than gross misconduct on the employee's part).

A covered spouse of a County Employee has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following events:

- 1. the death of the employee;
2. the termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
3. a divorce or legal separation from the employee; or
4. the entitlement of the employee to Medicare.

A covered dependent child* of a County Employee has the right to choose continuation coverage if coverage under the Plan terminates due to one of the following events:

* A dependent child includes a newborn child, an adopted child, and a child placed with the covered employee for adoption, during the COBRA Coverage Period. The COBRA Coverage Period ends at the same time as the other family members.

- 1. the death of the parent employed by the County;

- 2. the termination of employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment with the County;
3. the divorce or legal separation of the dependent child's parents;
4. the entitlement to Medicare of the parent employed by the County; or
5. the dependent child's ineligibility for coverage as a "dependent child" under the Plan.

Coverage may be continued for 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage. Coverage may be continued for 18 months in the event of termination or reduction in hours of employment.

*A dependent child includes a newborn child, an adopted child, and a child placed with the covered employee for adoption, during the COBRA Coverage Period. The COBRA Coverage Period ends at the same time as the other family members.

The 18-month coverage period may be extended to 29 months for covered family members, if: (i) any covered family member (employee, spouse, or dependent child) is determined under Title II or Title XVI of the Social Security Act to have been disabled on or within 60 days of the date of termination or reduction in hours of the covered employee's employment; and (ii) the covered employee or a qualified beneficiary notifies the County within 60 days after the determination and before the end of the 18-month coverage period. Any coverage extended after the initial 18 months because of a disability determination may be charged to the covered person(s) at 150% of the group rate (even if coverage is ultimately continued for a total of 36 months, pursuant to the paragraph below), so long as the disabled person is covered during the extension. If it is later determined that the covered family member whose disability resulted in the extended coverage is no longer totally disabled, the covered employee or a qualified beneficiary must notify the County within 30 days of the determination.

If a covered spouse or dependent child continues coverage upon a termination or reduction in hours of employment, continuation coverage may be extended to 36 months if another event (death, divorce or legal separation, Medicare entitlement, or ineligibility for dependent coverage) occurs during the initial 18-month period. If one of these events occurs, the covered employee or another qualified beneficiary should notify the County right away. Continuation coverage will not last beyond 36 months from the date of the first event that made the covered person eligible to continue coverage. However, special rules

may apply if Medicare entitlement is involved.

It is the responsibility of the covered person to notify the County within 60 days of the date of a divorce, legal separation, or a child losing dependent status under the Plan.

Continuation coverage may be cut short for the following reasons:

1. The County no longer provides group health benefits coverage to any of its employees;
2. The covered person fails to make timely payment of any premium due;
3. After electing continuation coverage, the covered person becomes covered under another group health benefits plan that either: (i) does not contain any exclusion or limitation; or (ii) contains an exclusion or limitation that does not apply to the covered person or has been satisfied in accordance with federal law;
4. After electing continuation coverage, the covered person becomes entitled to Medicare; or
5. Continuation coverage has been extended for up to 29 months due to a covered family member's disability, and there has been a final determination that the family member is no longer totally disabled.

To continue coverage, the covered person must submit a written election form to the County within 60 days of the later of: (i) the date on which coverage terminates due to one of the events specified above; or (ii) the date additional notice is given of the right to continue coverage under the Plan. If an election form is not returned by or on behalf of a covered person within that 60-day period, it will be assumed that he/she does not wish to continue coverage under the Plan.

If an election is made to continue coverage, a covered person will be required to pay the premium for the coverage. Except with respect to continuation coverage extended for up to 29 months for a disabled person and any other covered family members whose coverage is extended with the disabled person's (or up to 36 months in the event that a second qualifying event occurs with respect to a qualified beneficiary whose coverage is extended due to disability), the premium payment will not exceed 102% of the group rate for the benefits, which includes an administration fee. If desired, premiums may be paid on a monthly basis. The covered person will be required to pay the first premium payment in advance, along with any retroactive premium payments owed from the date of termination of coverage, within 45 days after submitting

the written election form.

Continuation of Coverage under New York State Law

If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law. Contact the County to find out if you are entitled to temporary continuation of coverage under COBRA or under New York Law.

Under New York Law, if a covered employee loses coverage because of termination of employment or membership in the class or classes eligible for coverage, the employee may continue coverage for him/herself and eligible dependents, subject to the following.

1. The covered person is not entitled to Medicare; and is not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions.
2. The covered person must request continued coverage within 60 days after the later of: the date of termination; or the date he/she is given notice of continuation by the County. If the covered person wishes to continue coverage for up to 29 months due to a Social Security Disability (see 4.d. below), he/she must notify the County within 60 days after a determination and before the end of the period that he/she was disabled under the Social Security Act at the time of termination of employment or membership or within the first 60 days of continuation coverage.
3. The covered person must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date the covered person is given notice of continuation by the County. The premium cannot exceed 102% of the group rate.
4. Coverage will terminate at the earliest of the following:
 - a. the date 18 months after the covered person's coverage would have terminated because of termination of employment or membership;
 - b. The date to which premiums are paid, if the covered person fails to make a timely payment;

- c. If the covered person is an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; ineligibility for dependent child status under the Plan;
- d. The date 29 months after coverage would have otherwise terminated because of termination of employment or membership, if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in a. above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
- e. The date the County no longer provides coverage to any of its employees or members.

Continued Benefits after Termination for Total Disability under New York State Law

- 1. When Benefits May Be Continued. When a covered person is totally disabled, he or she may continue benefits for covered services to treat the total disability, if one of the following applies.
 - a. Termination of Employment, Eligibility, or Plan. When coverage under this Plan ends because:
 - i. the covered person is no longer actively employed;
 - ii. the covered person is no longer eligible for coverage under the Plan; or
 - iii. the Plan terminates;

coverage will be provided under the Plan during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay and/or surgery must be for treatment of the injury, illness, or pregnancy causing the total disability.
 - b. Termination of Active Employment. If coverage ends because the covered person is no longer actively employed, benefits will be provided during a period of total disability for up to 12

months from the date coverage ends for covered services to treat the injury, illness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

- 2. When Continued Benefits End. The continued benefits will terminate when:
 - a. the covered person has used all the Plan benefits available;
 - b. the Plan Administrator determines that the covered person is no longer totally disabled;
 - c. the covered person reaches the lifetime maximum amount payable under the Plan;
 - d. benefits are continued under a. above, and the covered person reaches the end of the 12-month period from the date coverage under this Plan ends.

The Plan will never pay more than the payments that would have been available, had a covered person remained covered under the Plan.

SUBROGATION

In the event that a covered person suffers an injury or illness for which another party may be responsible, such as someone injuring the covered person in an accident, and the Plan pays benefits as a result of that injury or illness, the Plan will be subrogated and succeed to the right of recovery against the party responsible for the covered person's illness or injury to the extent of the benefits paid by the Plan.

Duty to Cooperate with the Plan - Possible Penalties for Failure to Cooperate.

Under certain circumstances, the Plan is also entitled to be reimbursed for the benefits paid from a settlement or a judgment received by the covered person from or on behalf of the party responsible for the illness or injury. This and other penalties that apply under certain circumstances are noted below. Those circumstances are:

1. The settlement or judgment received by the covered person from the party responsible for the covered person's illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which the Plan has paid benefits; or
2. The covered person fails to cooperate with the Plan in proceeding against the party responsible for the covered person's illness or injury, to recover the benefits paid by the Plan. The Plan will pay all expenses associated with a legal action instituted on the Plan's initiative.

The penalty for failing to cooperate under 2. above is that the covered person will be responsible to repay to the Plan the amount of the benefits paid by the Plan. The Plan will invoke its rights under 2. above only when the covered person's illness or injury caused by a third party results in expenditures of more than \$500 by the Plan on behalf of the covered person. In any of these provisions where the Plan must give prior written consent, the Plan will not unreasonably withhold prior consent. The Plan will waive all penalties under these provisions if the Plan does not give or withhold its prior consent within 30 days from the date the covered person or his/her legal representative seeks prior consent in writing from the Plan.

Right of Recovery

Whenever payments have been made by the Plan Supervisor with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of the coordination of benefits provision, the Plan Supervisor shall have the right to recover such payments to the extent of such excess, from one or more of the

following, as Plan Supervisor shall determine:

Any person to, or for, or with respect to whom such payments were made; or
Any insurance company;
Any other organization of the type which provides services, or pays any benefits of the kind defined within this Plan.