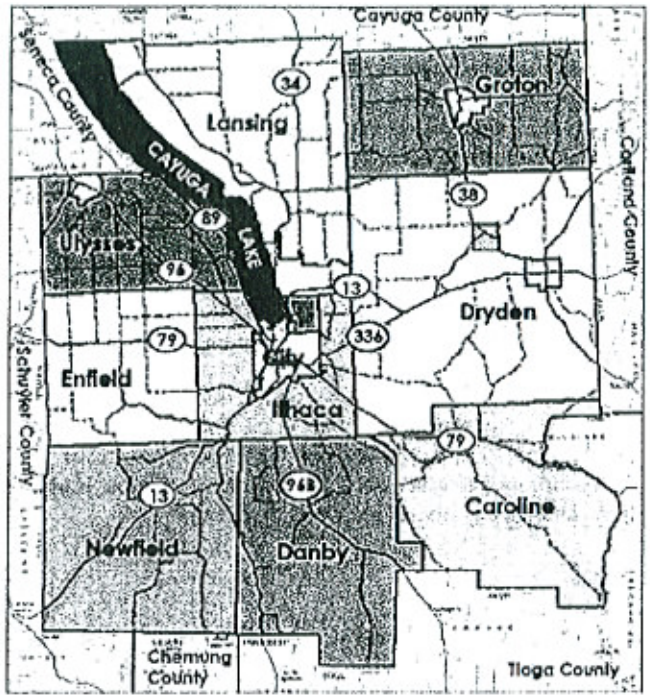
Greater Tompkins County Municipal Health Insurance Consortium



PPO Plan 10-A

Greater Tompkins County Municipal Health Insurance Consortium Participants:

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

Initial Draft (07-29-2009)
Effective Date: January 1, 2010

PLAN DOCUMENT

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

EFFECTIVE DATE

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

FUNDING

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

RIGHTS OF EMPLOYEES

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

CLAIMS ADMINISTRATOR

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

MISSTATEMENT OF AGE

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

LEGAL ACTIONS

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

PAYMENTS UNDER THE PLAN

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

RIGHT TO RECEIVE AND RELEASE INFORMATION

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

DATE EXPENSES ARE INCURRED

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

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

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

DEDUCTIBLE AMOUNTS

For those expenses not covered at 100%, the individual deductible amount stated in the Benefit Summary Section of this Plan Document (Page 27) must be incurred with respect to a covered person before benefits become payable. If, during a plan year, such deductibles are equal to the family deductible shown in the Benefit Summary Section of this Plan Document (Page 27), no further deductible amount shall apply with respect to any remaining expenses incurred by members of that family during the remainder of that calendar year. *For the purposes of this provision, a "family" means a covered employee and his or her covered dependents.*

COVERED MEDICAL EXPENSES - Medical Case Management

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

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

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

CONTRIBUTIONS

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

INCORPORATION OF SUMMARY PLAN DESCRIPTION

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

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

Section Title	Page Number
Summary Plan Description Introduction	6
General Information	7
Eligibility	8
Plan Information	16
Benefit Summary	19
What The Medical Plan Covers	28
What The Plan *Does Not* Cover (General Exclusions)	51
Definitions	56
General Provisions	67
Review and Appeal	68
Coordination of Benefits	77
Medicare Eligible Employee Coverage	80
Situations Affecting Plan Benefits	81
Continuation of Coverage	82
Employee Conversion Option	86

Initial Draft (07-29-2009)
Effective Date: January 1, 2010

SUMMARY PLAN DESCRIPTION INTRODUCTION

SUMMARY PLAN DESCRIPTION OVERVIEW

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

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

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

The benefits described in the Summary Plan Description are in effect as of January 1, 2010.

PLAN COSTS

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

Plan Name

The Greater Tompkins County Municipal Health Insurance Consortium PPO Plan 10-A

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

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

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

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

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

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

Type of Plan

Group Health Benefits Plan

Type of Administration

Contract Administration

The Sources of Contributions to the Plan

Employer, Employee, and Retiree contributions

Plan Year

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

ELIGIBILITY

ELIGIBLE EMPLOYEES

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

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

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

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

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

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

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

Waiting Period

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

Late Enrollment

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

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

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

Late Enrollment (Cont.)

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

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

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

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

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

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

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

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

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

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

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

Date of Coverage

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

When Coverage Begins

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

Retiree Eligibility

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

Survivor's Coverage

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

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

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

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

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

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, or pre-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 25 (if a student enters military service and, after discharge, returns to school, s/he may be covered beyond 25 years of age for the same number of months s/he spent in military service, not to exceed four (4) years);

Dependent on the covered person for financial support and maintenance (dependency will be determined in part by IRS guidelines relating to the determination of a qualified dependent for tax purposes); 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;

A step-child;

A child for whom the covered person is the legal guardian; or

Dependent Coverage (Cont.)

Any child supported by the covered person who permanently resides in the household of which the covered person is the head, provided such support and residence commenced before the child reached age 19.]

Natural children, adopted children or children ordered to be covered by court decree who do not reside with the covered person may also be eligible for coverage, subject to the criteria noted in this section.

Young Adult Option:

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

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

Young Adult:
The Young Adult must be unmarried; be 29 years of age or younger; not be insured by or eligible for comprehensive (i.e. medical and hospital) health insurance through his or her own employer; and must live, work or reside in New York State or the health insurance company's service area.

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

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

ALL OTHER PERSONS ARE EXCLUDED FROM COVERAGE UNDER THIS PLAN.

When Dependent Coverage Stops

Dependent coverage normally stops when the dependent 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 83).

Ineligible Dependents

In no event will an individual be a dependent under the Plan if enrollment is attempted after a covered person's retirement, unless dependent status occurs after the covered person's retirement, subject to the HIPPA exceptions set forth in the Section entitled LATE ENROLLMENT (Page 9).

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.

Enrolling Dependents

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

Enrollment Changes

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

Marriage or divorce;

Birth, adoption, or pre-adoption;

Death of a spouse or a child;

Loss of group insurance by spouse.

Adopted Children

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

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

PROVISIONS RELATED TO QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Purposes

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

Definitions

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

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

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

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

Relates to benefits under this Plan.

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

Qualified Medical Child Support Order (QMCSO)

A Medical Child Support Order to be qualified must clearly:

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

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

Specify each period to which such order applies; and

Specify each plan to which such order applies.

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

Procedures

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

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

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

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

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

Medicare Eligibility

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

The Plan has contracted with a group of Physicians, Hospitals, and other Ancillary Providers who may be used by covered persons to provide covered services described in this Summary Plan Description. A list of the participating providers is included with your enrollment packet and is available on-line at the Excellus BCBS web site of www.excellusbcbs.com. Additional copies of the provider directory or questions about specific providers may be obtained by contacting the Excellus BCBS Customer Service Department at: 1-877-755-3850. Upon enrollment in the Plan, covered persons will receive information describing how to access the list of participating medical providers and facilities. Please note, each individual participating municipality has not contracted directly with any health professional nor do they promote one health professional over another.

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

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

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

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

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

There are separate payment levels under this Plan for participating and nonparticipating providers. The benefits for participating providers are generally higher than those for nonparticipating providers. The benefit amounts and limits with respect to covered services by both participating and nonparticipating are shown in the section entitled BENEFIT SUMMARY (Pages 19-27).

A participating provider has an agreement with the Plan to accept payment for covered services based on a predetermined fee schedule. Therefore, a covered person will not be responsible for any charges, other than applicable co-payments, which exceed the participating provider's fee schedule. When a nonparticipating provider is used the covered person is responsible for the deductible, 20% coinsurance, and any provider charges that are in excess of the Allowable Expense. Please see Page 18 for further information about the Allowable Expense.

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 Greater Tompkins County Municipal Health Insurance Consortium. If there are no in-network participating providers, or if there are not the appropriate in-network specialists in the area in which a covered person seeks service, in-network benefits shall be available at the discretion of the Plan Administrator.

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

OUT-OF-AREA COVERAGE (Cont.)

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

OUT-OF-NETWORK DEDUCTIBLE & COINSURANCE

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

For any amounts in excess of the deductible amount as set forth in the section entitled BENEFIT SUMMARY, specifically on page 27, 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 Carryover Provision - If any part of the deductible amount has been satisfied during the last three months of a calendar year for services rendered in the last three months of that calendar year, the deductible amount for the next calendar year will be reduced by that amount.

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

OUT-OF-POCKET MAXIMUMS

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

The covered person pays a total of the out-of-pocket maximum amount as set forth in the section entitled BENEFIT SUMMARY, specifically on page 27, 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, specifically on page 27, 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 with this exception: any in-network co-payments equal to or in excess of $50 that are paid by a covered person will count towards the out-of-pocket maximum. Any other deductibles, in-network co-payments, prescription drug co-payments, or amounts that the covered person pays to a non-participating provider in excess of the Allowable Expense will not count toward the individual or family out-of-pocket maximum amounts.

ALLOWABLE EXPENSE

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

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

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

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

MAXIMUM BENEFIT

The amount payable under the Plan for all covered medical expenses incurred by any covered person during the maximum benefit period as set forth in the section entitled BENEFIT SUMMARY shall not exceed the applicable maximum benefit specified in the section entitled BENEFIT SUMMARY, specifically on page 27.

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 27 - 46), AND "WHAT THE MEDICAL PLAN DOES NOT COVER" (PAGES 47 - 51).

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

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

Allowable Expense (AE) For any services performed by an out-of-network provider, the covered person is responsible for any charges in excess of the Allowable Expense (AE). The Plan has set the Allowable Expense at the lower of: the national Medicare fee schedule amount for the Calendar Year prior to the Calendar Year in which the services are rendered; or the provider's charge, whichever is less. Because of this, the Plan strongly encourages individuals to discuss, in advance, whenever possible, with out-of-network providers, the cost of their services. The plan administrator will be able to assist in determining the amount, if any, of the charges that are in excess of the Allowable Expense (AE). Please see Page 18 for further information about the Allowable Expense.

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

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Anesthesia (In and outpatient)		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Assistant Surgeon		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Chemical Dependence		
Inpatient		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Outpatient (Up to 20 may be used for family counseling)		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance
Chiropractic Care (Benefit limited to medical necessity)		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay	20% of AE 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 AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance

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

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

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

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

Dialysis

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

Durable Medical Equipment (Including orthotic devices)

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

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

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

Home Health Care

		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays: and any remaining balance	0% of contracted rate	20% of AE amount

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	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)

		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE 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)

The Plan pays:	100% of contracted rate minus co-pay	100% of AE Amount minus co-pay
The covered person pays:	$35 co-pay (Waived if admitted)	$35 co-pay (Waived if admitted)

Hospital Room & Board

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

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

The Plan's payment for In-Network and Out of Network services will be the based on the type of service provided with percentages and copayments similar to those listed for "like" services in this Summary.

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

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

Maternity (Including prenatal, delivery, and post-partum care)
(This benefit is for the physician's services, the $75 hospital inpatient co-pay will apply to the inpatient delivery)

		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay for initial visit only Remaining visits paid in full	20% of AE amount and any remaining balance

Birthing Center and Midwife		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Medical Supplies		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Newborn Baby Care (Facility and professional charges)		
		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Organ/Tissue Transplants		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Physician Services		
INCLUDES:		
Office/Home Visits		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance
Diagnostic X-ray/Labs		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Inpatient Hospital Visit (Benefit limited to one visit per day)		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Inpatient Consultation (Benefit limited to one visit per day)		After deductible
The Plan pays:	100% of contracted rate	80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Podiatry		After deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance

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

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

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

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

Retail Pharmacy (limited to a 30 day supply):

Tier 1 (Generic Medications):	The covered person pays:	$5.00 Per Prescription
Tier 2 (Preferred Brand Name Medications:	The covered person pays:	$10.00 Per Prescription
Tier 3 (Non-Preferred Brand Name Medications:	The covered person pays:	$25.00 Per Prescription

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

Tier 1 (Generic Medications):	The covered person pays:	$10.00 Per Prescription
Tier 2 (Preferred Brand Name Medications:	The covered person pays:	$20.00 Per Prescription
Tier 3 (Non-Preferred Brand Name Medications:	The covered person pays:	$50.00 Per Prescription

Preventive Care

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

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

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

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

Prosthetic Devices

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

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

Psychiatric Benefits

Inpatient

		After Deductible
The Plan pays:	100% of contracted rate minus co-pay	80% of AE Amount
The covered person pays:	$75 co-pay	20% of AE Amount and any remaining balance

Outpatient

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

The benefits for Biologically Based Mental Illness and for Children with Serious Emotional Disturbances are not subject to any day limit for inpatient days or outpatient visit limits that may apply to mental health care and will be comparable to the benefits provided for medical conditions under this Plan Document.

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

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

		No written referral: After deductible
The Plan pays	100% of contracted rate minus co-pay	80% of AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance With written referral: In-network benefit paid

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

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

Skilled Nursing Facility Care (Benefit limited to 120 days per calendar year maximum) (Admission must be within 30 days of a prior hospital stay.)

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

BENEFIT FEATURES:	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Surgery: Physician's Charge (Inpatient and Outpatient)		
The Plan Pays:	100% of contracted rate	After deductible 80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Therapy including (but not limited to): Cardiac, Infusion Respiratory, Chemo, Oxygen, Radiation, Shock, Diabetes - limited to state mandated benefit		
Above services are all subject to the following:		
The Plan Pays:	100% of contracted rate	After deductible 80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Therapy (Occupational, Physical, Respiratory, and Speech): (Benefit limited to a 45 combined visit maximum per calendar year maximum)		
Inpatient		
The Plan Pays:	100% of contracted rate	After deductible 80% of AE amount
The covered person pays:	0% of contracted rate	20% of AE amount and any remaining balance
Outpatient		
The Plan Pays:	100% of contracted rate minus co-pay	After deductible 80% of AE amount
The covered person pays:	$10 co-pay	20% of AE amount and any remaining balance
Urgent Care Center		
The Plan Pays:	100% of contracted rate minus co-pay	After deductible 80% of AE amount
The covered person pays:	$25 co-pay (Waived if admitted)	20% of AE amount and any remaining balance

BENEFIT FEATURES:		IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Exclusions:	see the section entitled GENERAL EXCLUSIONS (Pages 51 - 55) in this Summary Plan Description for further details.		
Deductible:	Individual:	$ 0	$250
	Family:	$ 0	$750
Out-of-Pocket Maximum:			
	Individual:	N/A	$1,000 plus deductible
	Family:	N/A	$3,000 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 Allowable Expense 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: Unlimited

Please Note: The phrase "the Plan pays the allowable amount" refers to the medically necessary covered services and supplies that are eligible for benefits, subject to the benefits, limitations, and exclusions outlined throughout this Summary Plan Description. For in-network services, the allowable amount is the contracted rate less any co-payments. For out-of-network services, the allowable amount is the AE amount less any deductibles and coinsurances. The cost sharing component between the Plan and the covered person is defined in the section entitled BENEFIT SUMMARY (Pages 19 - 27) 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 (R.N.A.), under the direct supervision of a physician, during a covered surgery or maternity service at an inpatient or outpatient facility. One payment includes the consultation before anesthesia service is given and the provider's services during and after surgery or maternity services.

Assistant Surgeon Benefit

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

Bereavement Benefits

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

Blood and Blood Plasma (Including Blood Transfusions)

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

Bone Density Testing

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

Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or

On a prescribed drug regimen posing a significant risk of osteoporosis; or

With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

Cardiac Rehabilitation Services (Therapy)

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

Chemical Dependence - Inpatient

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

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

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

Chemical Dependence - Outpatient

The Plan pays the allowable amount for medically necessary outpatient treatment of chemical dependence. Up to 20 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. Please note, this care must be medically necessary and not custodial in nature or for maintenance treatment, and must be within the scope of licensure of the health care professional.

Consultation Expense Benefit

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

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

Diabetic Equipment and Supplies

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

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

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

Diabetes Education

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

A covered person is initially diagnosed with diabetes;

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

It is determined that reeducation or refresher education is necessary.

The self-management education must be provided by:

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

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

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

Dental Services

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

Dialysis

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

Diagnostic X-Ray and Laboratory (Outpatient)

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

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

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

Examples of such durable medical equipment are respirators, canes, crutches, walkers, and wheelchairs. Such equipment does not include, for example, air conditioners, dehumidifiers, physical fitness equipment, hearing aids, 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 covers facility services and supplies used for the initial treatment and all follow-up care within 48 hours of traumatic bodily injuries resulting from an accident. However, if the accident services are classified as surgery (e.g., suturing, burn care, fracture care, etc.) payment will be made as a surgical benefit.

Gynecology (Routine)

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

Home Health Care Services

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

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

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

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

It is determined that home health care is medically necessary.

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

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

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

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

Nutritional counseling; and

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

The above benefits will be covered when:

They are ordered by the physician; and

They are furnished in the patient's home.

Hospice Care

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

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

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

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

It is determined that hospice care is medically necessary; and

The covered person is formally admitted to the hospice program.

Covered Benefits Include Only the Following:

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

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

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

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

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

The maximum lifetime benefit for hospice care is 210 days.

Hospital Benefits

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

A registered bed patient;

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

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

Hospital Benefits (Cont.)

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

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

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

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

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

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

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

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

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

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

Infertility Treatment Services

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

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

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

Infertility Treatment Services (Cont.)

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

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

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

Services in relation to diagnostic tests and procedures necessary:

To determine infertility; or

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

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

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

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

Infertility Treatment Services (Cont.)

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

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

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

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

Inpatient Physician Services

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

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

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

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

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

Mammography

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

Maternity Care

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

Medical Supplies

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

Newborn Care

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

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

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

Oral Surgery

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

Organ/Tissue Transplants

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

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.

Pre-Surgical Testing

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

Proper diagnosis and treatment require the tests;

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

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

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

Prescription Drugs

The Plan pays for medically necessary prescription drugs.

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

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

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

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

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 (typically a 30 day supply, but covered up to a 90 day supply):
The covered person pays: $ 5 for Tier I drugs
The covered person pays: $ 10 for Tier II drugs
The covered person pays: $25 for Tier III drugs

Mail-Order Pharmacy (typically a 90 day supply):
The covered person pays: $10 for Tier I drugs
The covered person pays: $20 for Tier II drugs
The covered person pays: $50 for Tier III drugs

Prescription Drugs (Cont.)

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

Tier I – drugs are typically generics and have the lowest copayment amount.

Tier II – drugs are brand name drugs that have unique, significant clinical advantages and offer overall greater value over the other products in the same drug class.

Tier III – drugs are all other brand drugs, including new brand drugs and drugs that have generic equivalents. Tier III drugs have the highest copayment amount.

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

Necessary for the care and treatment of an illness;

Prescribed in writing by an authorized physician;

Reasonable and customary; and

Not listed in the Exclusion section, below.

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

Mail Order Program

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

How to use the program:

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

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

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

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

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

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

Prescription Drug Exclusions:

The following exclusions apply to the prescription drug benefit:

Non-legend drugs, other than injectable insulin.

The charges for the administration or injection of any drug.

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

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

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

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

Prescription Drug Exclusions (Cont.)

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

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

Immunization agents, biological sera, blood or blood plasma.

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

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

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

Growth Hormones.

Infertility Medications.

Smoking deterrent medications.

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

Preventive Care

The Plan 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, as defined by §1.03 (10) of the Mental Hygiene Law. Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.

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

Psychiatric Treatment - Outpatient

The Plan pays the allowable amount for medically necessary professional provider services for the outpatient diagnosis and treatment of a mental, nervous, or emotional disorder.

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

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

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

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

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

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

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

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

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

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

Radiation Therapy

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

Reconstructive or Corrective Surgery

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

To correct an abnormal congenital condition in a child,

To repair or alleviate damage which occurred as the result of an accident,

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 30 days of a prior hospital stay.

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

A registered bed patient in a skilled nursing facility; and

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

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. 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 Advisory Committee on Immunization Practices (ACIP), 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.

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. This exclusion only applies if the covered person is eligible for benefits from another insurance carrier for the dates services were rendered . However, after the discharge from the facility or program, benefit payments for future covered services will be provided.

3. Any 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 a participating municipality; and

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

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

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

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

General Exclusions (Cont.)

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 received by the covered person 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 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 AE amount. See Page 13.

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.

General Exclusions (Cont.)

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

18. Expenses applied toward satisfaction of the deductible.

19. 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.

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

21. Expenses for a standby physician.

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

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

24. Any expense for career or pastoral counseling.

25. 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.

General Exclusions (Cont.)

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.

26. 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.

27. Charges for the reversal of any sterilization procedure.

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

29. Charges for orthoptic therapy (vision exercises).

30. Services for weight reduction programs.

31. 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.

32. Hypnosis.

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

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

35. Mail and/or shipping and handling expenses.

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

37. Sale(s) tax.

38. Adoption expenses.

General Exclusions (Cont.)

39. 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.

40. 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.

41. 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.

42. 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.

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

It provides a physician trained in cardiopulmonary resuscitation.

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

DEFINITIONS

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

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

Makes charges.

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

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

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

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

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

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

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

Accepts only patients with low risk pregnancies.

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

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

Keeps a medical record on each patient and child.

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

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

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

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

DEFINITIONS

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

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

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

Convalescent Hospital: (Cont.)

(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.

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;
One of the organs or other parts of the body could be seriously harmed; or
The person could be seriously disfigured.

DEFINITIONS

Employer: A participating municipality in Tompkins County.

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

This includes, but is not limited to:

All phases of clinical trials;

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

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

Federally approved drugs used for unrecognized treatment indications.

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

Extended Care Facility: Any one of the following:

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

All the following must be true. The facility must:

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

It must provide all the following:

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

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

DEFINITIONS

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

DEFINITIONS

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

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

It must have organized departments of medicine and surgery;

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

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

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

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

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

A hospital must also:

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

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

Ensure that each specialized program provided by it must:

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

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

A Hospital must also:

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

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

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

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

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

Hospital: (Cont.)

Is operated primarily as a school.

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

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

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

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

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

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

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

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

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

Necessary to meet a patient's basic health needs;

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

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

The most appropriate method of providing safe and adequate care.

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

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

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

Medically Necessary/Medical Necessity: (Cont.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan: The Greater Tompkins County Municipal Health Insurance Consortium PPO Plan 10-A.

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

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

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

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

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

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

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

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

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

Must be licensed to give medical treatment;

Is operated under the supervision of a physician;

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

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

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

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

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

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

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

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

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

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

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

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

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

Has a utilization review plan; and

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

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

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

Supervising Doctor: The physician directing the Hospice Care Program.

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

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

TMJ: The abbreviation for temporomandibular joint syndrome.

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

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

Submitting a Claim:

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

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

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

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

Choice of Provider:

The covered person has free choice of any provider.

Assignment:

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

Exam:

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

Legal Action:

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

Loss of Benefits:

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

APPEALING A CLAIM

Claims Other Than Medical Necessity or Experimental/Investigational Services

This section describes the appeal process that applies to a claim denied, in whole or in part, for a reason other than a lack of medical necessity or the experimental/investigational nature of the service. (If a claim relates to medical necessity or the experimental/investigational nature of the service, please refer to the Section titled "Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure" on Page 65 for the applicable claim determination and appeal procedure.)

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

If a covered person does not agree with the denial of a claim, the covered person may call the claims clerk on the toll-free number (1-800-722-0782). If the claim is not resolved to the covered person's satisfaction, the covered person should then speak to the manager of the plan administration office. At that point, a final determination will be made by the plan administrator. The covered person will be notified in writing of the plan administrator's determination. A review by the Executive Committee of the Plan and/or arbitration may be available; see the Sections titled "Review By the Executive Committee" and "Arbitration" below.

Review By the Executive Committee

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

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

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

Arbitration

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

Arbitration (Cont.)

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

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

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

Given the voluntary nature of the Plan's managed care program (please see page 14), most of the UR procedures under this section including the pre-admission review process and the concurrent review process will not be applicable unless the covered person requests such a review.

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

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

Utilization Review Procedure

The steps of the UR procedure are as follows:

1. PRE-ADMISSION REVIEW PROCESS

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

Utilization Review Procedure - Pre-Admission Review (Cont.)

b. Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to the covered person, a designee authorized in writing by the covered person (if any), and the provider, by telephone and in writing, within three (3) business days following receipt of all information necessary to make the decision.

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

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

2. CONCURRENT REVIEW PROCESS

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

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary and not experimental and/or investigational. If so, the nurse will authorize the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

c. The provider will be notified of the concurrent review decision, by telephone and in writing, within 1 business day following the receipt by the plan administrator of all information or documentation needed for the review.

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

Utilization Review Procedure - Concurrent review process (Cont.)

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

3. RETROSPECTIVE REVIEW PROCESS

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

b. The covered person, an authorized designee, and the provider will be notified of the retrospective review determination, in writing, within 30 calendar days from receipt by the plan administrator of all information or documentation needed for the review.

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

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

4. REVIEW OF ADVERSE DETERMINATIONS

a. *Request for internal appeal*

i. The covered person, an authorized designee, and, in a retrospective review case, the health care provider may request an internal appeal of an adverse determination, verbally or in writing, within 45 days from the date that notice of the adverse determination is received. (If the notice received does not specify all information required to conduct an internal appeal, the time period for appealing will be extended.) To submit an internal appeal verbally, the covered person, an authorized designee, or the provider may call 1-800-722-0782. To submit a written internal appeal, the covered person, an authorized designee, or the provider may write to the plan administrator.

Utilization Review Procedure - Request for Internal Appeal (Cont.)

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

b. *Standard internal appeal*

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

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

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

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

c. *Expedited internal appeal*

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

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

Utilization Review Procedure - Expedited Internal Appeal (Cont.)

iii. Within 2 business days of receipt by us of all information needed for the appeal, the clinical peer reviewer will render a determination on the expedited internal appeal. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

iv. Notice will be provided to the covered person, an authorized designee, and the provider, in writing, within 24 hours of the determination. The notice will include all of the information described and enclosed in a notice of standard internal appeal determination (see subparagraph b. iv. above), and will describe the right to a standard internal appeal following an adverse determination on expedited internal appeal. The covered person, an authorized designee, and, where appropriate, the provider will be advised that, if a standard internal appeal is requested after the expedited internal appeal, the standard internal appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date of receipt of the final adverse determination notice upon completion of expedited internal appeal.

d. ***External appeal***

i. *In general*. A covered person has the right to an "external appeal" of certain coverage determinations made by or on behalf of the Plan. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by New York State; and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. In this section, "requested service" or "requested services" refers to the service or services for which coverage is requested.

A covered person may have the right to an expedited external appeal if the attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to the covered person's health. The time frames for expedited external appeals are shorter than the time frames for standard external appeals.

An external appeal may be requested only if the requested service is covered under the health benefits program.

ii. *Coverage determinations subject to external appeal*. This subparagraph describes the general conditions for external appeal.

In general, an external appeal may not be requested unless the Plan has issued a "final adverse determination" with respect to a request for coverage after the internal appeal (paragraphs b. and c. above). A covered person may ask the Plan to agree to an external appeal, even though a final adverse determination has not been issued after an internal appeal; however, the Plan has no obligation to agree to the request. If the Plan does agree, the plan administrator will send a letter to the covered person, stating that the Plan has agreed to an external appeal even though no final adverse determination has been issued.

Utilization Review Procedure - External Appeal (Cont.)

To be eligible for external appeal, the final adverse determination issued upon completion of an internal appeal must be based on a determination that the requested service is not medically necessary, or that the requested service is experimental and/or investigational. There is no right to an external appeal of any other determinations, even if those other determinations affect coverage.

iii. *Conditions for external appeal of determinations of medical necessity*. An external appeal may be requested with respect to a final adverse determination of medical necessity that is issued upon completion of internal appeal, if the conditions of this subparagraph and the general requirements of subparagraph ii. above are met. The provisions of this subparagraph apply only to external appeal of medical necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is or was not medically necessary.

Subparagraph vii. below provides information on requesting an external appeal.

iv. *Conditions for external appeal of determinations involving experimental and/or investigational treatment*. This subparagraph governs the external appeal of determinations involving experimental and/or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials, which are governed by subparagraph v. below.

To request an external appeal under this subparagraph, the attending physician must certify that the covered person has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of the attending physician, has a high probability of causing death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death; or that has lasted or can be expected to last for a continuous period of not less than 12 months; or that renders the covered person unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, the attending physician must certify that: standard health services or procedures have been ineffective, or would be medically inappropriate in treating the life-threatening condition or disease; or that no more beneficial standard treatment exists that is a covered service under the health benefits program.

The attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) that, based on at least two documents from the available medical literature, is likely to be more beneficial to the covered person than any standard covered health service or procedure. To make this recommendation, the attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat the life-threatening or disabling condition or disease.

If the requirements of this subparagraph and all of the requirements of subparagraph ii. above are met, an external appeal may be requested. Subparagraph vii. provides information on requesting an external appeal.

Utilization Review Procedure - External Appeal (Cont.)

v. *External appeal of determinations involving clinical trials*. This subparagraph governs the external appeal of determinations involving services provided in clinical trials.

To request an external appeal under this subparagraph, the attending physician must certify that the covered person has a life-threatening or disabling condition or disease as described in subparagraph iv. above. In addition, the attending physician must certify that a clinical trial for the covered person's condition exists and that the covered person is eligible to participate in the clinical trial.

The attending physician must also recommend that the covered person participate in the clinical trial. To make this recommendation, the attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat the life-threatening or disabling condition or disease.

The clinical trial for which coverage is requested must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;

an entity that has been identified by the NIH as a qualified non-governmental research entity; or

an Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If the requirements of this subparagraph and all of the requirements of subparagraph ii. above are met, an external appeal may be requested. Subparagraph vii. below provides information on requesting an external appeal.

vi. *Effect of the External Appeal Agent's decision; coverage*. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in favor of the Plan, benefits will not be provided for the requested service. If the external appeal agent decides in favor of the covered person, the Plan will cover the service as follows:

for services denied as not medically necessary, the Plan will treat the service as medically necessary and provide coverage, subject to all other conditions of coverage.

for services denied as experimental and/or investigational, other than services provided in a clinical trial, the Plan will pay for the patient costs incurred for the services, subject to all other conditions of coverage.

for services denied as experimental and/or investigational that are provided in a clinical trial, the Plan will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for drugs or devices that are the subject of the clinical trial.

Benefits will not be provided for any service that is not a covered service under the program. In addition, this external appeal right does not alter the covered person's cost-sharing responsibilities, if any, as otherwise provided in the program.

Utilization Review Procedure - External Appeal (Cont.)

vii. *Requesting an external appeal.* If the conditions described in the previous paragraphs are met, an external appeal may be requested by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided, the provider may file an appeal on behalf of the covered person. The Plan administrator will send a standard external appeal request form to the covered person when a final adverse determination has been made upon completion of internal appeal. If a provider requested the internal appeal of a retrospective adverse determination, the provider will be sent a standard provider external appeal request form with the notice of final adverse determination. The covered person, an authorized designee, or a provider may obtain additional standard request forms at any time by calling the New York State Insurance Department at 800-400-8882 or by accessing its website (www.ins.state.ny.us); by calling the New York Department of Health at 518-486-6074 or by accessing its website (www.health.state.ny.us); or by calling our Customer Service Department.

A request for an external appeal must be filed with the New York State Insurance Department within 45 days of receiving a final adverse determination upon completion of internal appeal; or within 45 days of receiving a letter from the plan administrator waiving the internal review process. The Plan does not have the authority to grant extensions of this deadline.

The address for the New York state Department of Insurance is:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257

A standard internal appeal is available as an alternative to external appeal, if the internal appeal was expedited (see paragraph c. above); the standard internal appeal is optional after expedited internal appeal. However, whether or not a standard internal appeal is requested after expedited internal appeal, the application for external appeal must be filed with the New York State Insurance Department within 45 days from receipt of the notice of final adverse determination upon completion of the expedited internal appeal, to be eligible for review by an external appeal agent.

The Plan will charge a fee of $50 to request an external appeal. The covered person's fee may be waived if the plan administrator determines that paying the fee is a financial hardship. (If the external appeal is filed by a provider, the fee will not be waived.) The fee is returned if the external appeal is decided in favor of the covered person.

Questions regarding the external appeal process or the right to external appeal may be addressed to the plan administrator, the New York State Insurance Department, or the New York State Department of Health.

Covered persons are urged, but not required, to exhaust all levels of the appeal process before taking further action. No representative of the Plan shall, in any way, lead a covered person to believe that he or she is required to do so. If a covered person, authorized representative, or provider is not satisfied with the outcome of an issue, the New York State Insurance Department may be contacted. Upon request, the plan administration office will provide the appropriate telephone number and address for the Insurance Department.

COORDINATION OF BENEFITS

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 Allowable 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 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 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 Allowable Expense as used in this provision means any reasonable and customary charges for necessary medical or dental 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.

COORDINATION OF BENEFITS

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.

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

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

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

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

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

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

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

MEDICARE ELIGIBLE EMPLOYEE COVERAGE

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

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

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

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

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

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

SITUATIONS AFFECTING PLAN BENEFITS

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

Termination of Employment

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

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

Personal Leave of Absence

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

Medical Leave of Absence

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

Converting Medical Coverage

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

Attachment of Benefits

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

Discrimination Tests

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

Continuation of Coverage 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 an employee of a participating municipality has the right to choose continuation coverage if coverage under the Plan terminates because of a reduction in hours of employment or because employment has terminated (for reasons other than gross misconduct on the employee's part).

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

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

2. the termination of employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment with the participating municipality;

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

4. the entitlement to Medicare of the parent employed by the participating municipality; 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 36 months in the event of termination or reduction in hours of employment.

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

Continuation of Coverage under COBRA (Cont.)

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

Continuation coverage may be cut short for the following reasons:

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

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

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

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

5. Continuation coverage has been extended for up to 29 months due to a covered family member's disability, and there has been a final determination that the family member is no longer totally disabled.

To continue coverage, the covered person must submit a written election form to the participating municipality within 60 days of the later of: (i) the date on which coverage terminates due to one of the events specified above; or (ii) the date 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 s/he does not wish to continue coverage under the Plan.

If an election is made to continue coverage, a covered person will be required to pay the premium for the coverage. The premium payment will not exceed 102% of the group rate for the benefits, which includes 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.

At the end of the COBRA continuation coverage period, a covered person may enroll in an individual conversion health benefits contract, as described elsewhere in the Plan.

Continuation of Coverage under New York State Law

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

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

1. The covered person is not entitled to Medicare; and is not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions.

2. The covered person must request continued coverage within 60 days after the later of: the date of termination; or the date s/he is given notice of continuation by the participating municipality.

Continuation of Coverage under COBRA (Cont.)

3. The covered person must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date the covered person is given notice of continuation by the participating municipality. The premium cannot exceed 102% of the group rate.

4. Coverage will terminate at the earliest of the following:

   a. the date 36 months after the covered person's coverage would have terminated because of termination of employment or membership;

   b. The date to which premiums are paid, if the covered person fails to make a timely payment;

   c. If the covered person is an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; ineligibility for dependent child status under the Plan;

   d. The date 36 months after coverage would have otherwise terminated because of termination of employment or membership, if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in a. above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or

   e. The date the participating municipality no longer provides coverage to any of its employees or members.

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

1. When Benefits May Be Continued. When a covered person is totally disabled, he or she may continue benefits for covered services to treat the total disability, if one of the following applies.

   a. *Termination of Employment, Eligibility, or Plan.* When coverage under this Plan ends because:

      i. the covered person is no longer actively employed;
      ii. the covered person is no longer eligible for coverage under the Plan; of
      iii. the Plan terminates;

      Coverage will be provided under the Plan during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay and/or surgery must be for treatment of the injury, illness, or pregnancy causing the total disability.

   b. *Termination of Active Employment.* If coverage ends because the covered person is no longer actively employed, benefits will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, illness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

Continuation of Coverage under New York State Law (Cont.)

2. When Continued Benefits End. The continued benefits will terminate when:

   a. the covered person has used all the Plan benefits available;

   b. the Plan Administrator determines that the covered person is no longer totally disabled;

   c. 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.

EMPLOYEE CONVERSION OPTION

When an employee's medical care coverage under this Plan terminates, the medical benefits may be converted to an individual policy.

The conversion privilege is available:

To an employee if his/her coverage terminates and s/he has been covered for at least three months under this Plan.

To a dependent spouse if the coverage terminates because of an employee's death, or because of divorce, or an annulment of marriage provided the dependent spouse is not a covered person under a similar individual health insurance policy or similar group health insurance policy or plan.

To an employee's dependent child(ren) if their coverage terminates because of the dependent's age, or because of an employee's death provided the dependent child(ren) are not covered person(s) under a similar individual health insurance policy or similar group health insurance policy or plan.

The conversion privilege is not available to any covered person who is eligible for Medicare. Application and payment of the first premium must be made to the insurance company designated by the employer within 45 days immediately following termination of insurance under this Plan. If continuation of coverage as described above is elected, this conversion option will apply at the end of the maximum continuation period there under.